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CLINICAL LECTURE.

BASAL MENINGITIS.

BY LANDON CARTER GRAY, M.D.,
PROFESSOR OF NERVOUS AND MENTAL DISEASES IN THE NEW YORK POLYCLINIC.

Gentlemen: I shall read to you the history of a very interesting case of intracranial lesion:

Miss ——, forty-three years old, has all her life been troubled with weak eyes, her family being all near-sighted; but about five or six years ago she began to suffer with severe headache, and soon afterward observed that her eyes were failing more than had been the case with any other member of the family. She has never at any time during her life been much of a reader, because of the weakness of her eyes Last September the eyes became very much worse, so that she sought the advice of a well-known oculist. At that time she had temporal hemianopsia of the right eye in a vertical meridian. In the left eye a zone of diminished vision went five to ten degrees farther to the right side. Her sight was in the left = 1/6. Since that time the patient has become rapidly worse, so that the right eye, she tells me, is completely blind, whilst the left is almost so. The headaches have become much more severe. When she first came to me, February 4, 1887, she could distinguish the gas flame, and could tell that I had lifted up my arm between her and the light; but she could distinguish nothing more definitely. There was slight external strabismus of the right eye. The left eye was completely blind. The senses of smell, taste, and hearing were distinctly impaired on the left side, whilst the same senses were perfectly normal upon the right. The hand-grasp on the right was distinctly weaker than on the left. There was a slight difference in strength between the right and left legs, the right being the weaker. She told me that she was much weaker on the right side after a severe headache, that she would then stagger to the right, and that this weakness would persist for several days after an attack of headache. She also says that at the time of the special weakness of this right side she has dull aching throughout it. The headaches come with great suddenness, without the slightest apparent cause, and are accompanied with explosive vomiting; she may, perhaps, have one after a meal that has been eaten with perfect comfort. These headaches come every week or every few days, lasting several hours. There was absolutely no impairment of the senses of touch, temperature, pain, or of the muscular sense on the right side. The tendon reflexes were normal. She walked perfectly well, had no impairment of memory or of intellect, was a very intelligent woman, and in excellent general condition.

Upon this history, obtained over a year ago, I made the diagnosis of a lesion at the base of the brain. It was not a difficult matter to make a diagnosis of an intracranial lesion: the peculiar headache of the so-called cerebral type—*i. e.*, with explosive, seemingly causeless vomiting—and the hemianopsia; the impairment of the three special senses of taste, smell, and hearing, and the motor weakness of the right side after the headaches, constituted

ample data upon which to make a perfectly certain diagnosis of an intra-cranial lesion. It seems almost idle to say that a headache from extra-cranial causes would very seldom have this cerebral type; and, even if it did, it would not be accompanied by all the sensory and motor impairments that were present in this case. Occasionally, it is true, we meet with sudden vomiting in headaches due to nephritis, or in cases in which the urine may be found to be loaded heavily with uric acid crystals; but these cases have, of course, no motor or sensory paralyses. Nor was the question of localization of the lesion a difficult one. The cross-paralysis—*i. e.*, the paralysis of hearing, taste, and smell on the left side, and the motor paresis upon the right side—showed that the lesion must be at the base of the brain, implicating the nerves of smell, hearing, and taste on the left side and the crura cerebri on the same side. As you know, of course, the three nerves of smell, hearing, and taste would be distributed to their respective sense organs upon the same side, whilst the fibres in the crura cerebri would pass over to the opposite side when they had reached the region of decussation in the cord.

But there was, you will remember, external strabismus of the right eye, which means that there was paralysis of certain fibres of the right third nerve, or motor oculi; so that the lesion must have extended to the right side of the base of the brain, although it was mainly located upon the left. The nature of the lesion was not so easily determined. We should have to select, as the most probable causes, either intra-cranial syphilis, a tumor, or meningitis either of idiopathic, traumatic, or middle or internal ear origin. Intra-cranial syphilis was promptly excluded for several combined reasons: 1. The patient was an old maid of irreproachable life and habits; 2. Even admitting that life and habits count for nothing, or that the patient might have been inoculated through some buccal lesion, or in some other accidental way, the symptoms did not indicate any intra-cranial specific infection. As I have had occasion to demonstrate, intra-cranial syphilis has generally very well-marked symptoms of its own, consisting of a headache which has some quasi periodicity, and is often nocturnal; an obstinate insomnia going hand in hand with the headache; a distinct mental irritability accompanying the headache and the insomnia; and, finally, a remarkable cessation of the headache when a paralysis makes its appearance. As none of these symptoms were present in our patient, intra-cranial syphilis could be very certainly excluded.

The diagnosis, therefore, lay between meningitis of idiopathic, traumatic, or of middle or internal ear origin, or a tumor. There was absolutely no history of any trauma, and the most careful examination of the ear disclosed no other disease than that of the nervous apparatus on the left side, which has been described; nor was there any history of any ear trouble in the past. The diagnosis, therefore, still further narrowed itself down to a meningitis of idiopathic origin or a tumor. The neuro-retinitis was, of course, of no diagnostic use, because it might have been produced by either intra-cranial syphilis, tumor, or meningitis; and although there are differences in the early stages in the neuro-retinitis of these three different forms of intra-cranial trouble, no differences were apparent at the stage when our patient first came under observation. The space over which the lesion extends is a matter of considerable importance in the differential diagnosis. In this case, for instance, as you can see by any anatomical plate of the base of the brain, the lesion extends from the olfactory nerves backward to the crura cerebri, and still further back to the auditory and glosso-pharyngeal nerves on the left, and then it also affects the third nerve upon the right side. A meningitis, especially of the pia mater, would be much more likely than a tumor to cover such an extended area in so fragmentary a manner. A neoplasm, too, would have been much more likely to have caused more destruction and to have given rise to a large amount of mental hebetude if it had existed for so long a time and had spread over so wide an area.

A diagnosis was made of a meningitis, probably of the pia mater—a so-called lepto-meningitis—of the base of the brain. The prognosis was regarded as very serious; indeed, the patient's friends were told that, in all probability, death was merely a question of time. The patient was treated simply by means of the iodide of potash, given in increasing doses until forty grains were given three times a day; at times the inunction of mercurial ointment was ordered.

I lost sight of the patient until to-day (April 15), which is about one year after her first visit to me, and six or seven years after the beginning of her cerebral symptoms.

Now let us see what difference in symptoms there is.

She cannot see this gas flame, but she can see me between her and the window. Her sight is, therefore, slightly worse than it was a year ago. Let us test her sense of smell with the oil of thyme. As you know, a distinction must be made between the pungent odors, such as aromatic spirits of ammonia, which are perceived by the sensory filaments of the trigeminus in the nostril, and the pure odors, of which perception is gained through the olfactory nerve. Tested with this oil of thyme, therefore, we find that the sense of smell is now perfectly equal on the two sides, so that the impairment of smell on the left side has entirely disappeared.

We usually test the sense of taste by means of bitters, acids, and salts, using quinine as the type of the bitters, vinegar as the type of the acids, and common table-salt as the type of the salts. Then, again, it must be remembered that the nerve of taste in the anterior portion of the tongue is the chorda tympani, whilst in the posterior portion of the tongue it is the glosso-pharyngeal; so that these anterior and posterior regions must each be examined. The testing of taste is a very delicate matter, and often unsatisfactory with these tests. The best way is to have a little rod or match, with a small piece of absorbent cotton on the end. Dipping this into the test fluids, a drop should be placed carefully first on one side of the median line, and then upon the other, of the part of the tongue to be examined. Before doing this, however, the patient must be instructed to protrude the tongue, and to indicate when he tastes anything, by raising the hand; for, if he attempts to tell his sensation by speech, in goes the tongue, and the testing fluid is smeared all over the buccal cavity and the other portions of the tongue. But the best method of examination of the sense of taste is by the galvanic current. Only a few cells of any ordinary battery are needed, and the ends of the wires should be armed with long metal points. The strength of the current should first be tested upon your own tongue, so as to obtain only enough to give a savor and not enough to burn the tongue; these two metal points should be placed half an inch apart upon the portion of the tongue to be tested, and the patient instructed as before to indicate the presence of the sensation by uplifting the hand. Tested by all of these methods, we find that the sense of taste in our patient is still slightly impaired in the left anterior portion of the tongue, but that it is perfect in the left posterior portion; whereas it was entirely lost both anteriorly and posteriorly a year ago.

The strength of the hands is usually tested by means of the so-called dynamometer, with which all are familiar. But the neurologist comes to have a *manus erudita*, akin to the *tactus eruditus* of the gynecologist. Anyone can attain to considerable skill in the appreciation of strength in a hand-grasp when the matter has been studied through many years and in a long series of patients. I think I can tell the difference between the strength of hands as well with my hand as with a dynamometer. Tested by the hand and by the dynamometer, our patient is found to be equally strong on the two sides, so that the weakness of a year ago has disappeared.

Testing the hearing by the familiar methods of the watch, the voice, and the tuning-fork, it is found to be unimpaired on the left side; whereas a year ago she could not hear the ticking of a watch beyond eight inches, and could not distinguish low articulate sounds unless the speaker spoke directly into the ear.

But the crowning triumph of the treatment is shown in the condition of the headaches, for she tells me that they now never last more than five minutes; so that I almost think they are now no more than neuralgic twinges, inasmuch as they are never accompanied by either emesis or nausea.

This is an extremely interesting illustration of the chronicity of certain intracranial lesions. Whether the improvement is due to the inherent tendency to recovery or to the curative effects of treatment, who can tell? These cases do certainly seem to improve at times under medicines and special forms of treatment, and occasionally with such promptitude as to render it positive that the medication is to be credited with it. These curative agents are the iodides, mercury (preferably by inunction), cerebral galvanization, and occasional doses of quinine and bromide of potash. The iodides should be given in doses as high as twenty or thirty grains three times daily; the mercury should be rubbed into the armpits or into the soft flexor surfaces of the limbs. In the galvanization of the cerebrum large electrodes, well moistened with hot water, should be used, from three to five milliamperes of electricity being employed. Five grains of sulphate of quinine and thirty grains of bromide of potash should be given at bedtime every two or three weeks.

COMMUNICATIONS.

ANTISEPTIC SURGERY IN COUNTRY PRACTICE.[1]

BY J. M. TAYLOR, M.D.,
CORINTH, MISS.,
EX-PRESIDENT MISSISSIPPI STATE MED. ASSOCIATION AND OF MISSISSIPPI STATE BOARD OF HEALTH, ETC.

In medio tutissimus ibis.

One of the characteristic and distinctive features of this Association, I presume, will be the large element of country practitioners of surgery and gynecology who will constitute its membership. Doubtless a very large proportion of the reports that will be read at the annual meetings will represent the practice done in the comparatively small towns and villages and on the plantations and farms in the Southern States. Very few large hospitals or other eleemosynary institutions will be represented in it. Consequently, those subjects and those methods which more peculiarly interest and pertain to that class of practitioners should be selected for especial consideration in our deliberations. Simplicity of details, and economy both in time and in money, are matters of the very greatest importance to them. Many of them ride by day and by night, on horseback, in buggies, and on railroad trains, in all seasons, over the hills and through the swamps, carrying, in a pair of saddle-bags or a little hand-bag, all the medicines, instruments and appliances used by them in the treatment of all diseases and injuries, medical, surgical and obstetrical. They often visit a considerable number of patients on the same day, requiring diverse treatment, some of them many miles apart. In many instances they have to contend single-handed against poverty, ignorance and filth, separately or combined. Under such circumstances they can afford neither time nor money for non-essentials, either in theory or in practice. They soon become self-reliant, and learn to discard everything superfluous or unnecessary. No class of practitioners is less restrained by the formalities and the prescriptions of authority than they. Being more interested in the utilitarian than the speculative theories of the profession, they are sometimes in advance of their more fortunate (?) city brethren on practical questions, even though they should not be *au fait* in the latest sensation.

[1] Read at the meeting of the Southern Surgical and Gynecological Association, at Birmingham, Ala., Dec., 1888.

If half that has been said and written in behalf of antiseptic surgery were true, it is doubtful whether the country practitioner should feel more grateful for it as a great discovery, or more discouraged by the extravagant and impracticable conditions which it imposes. Although these conditions have been greatly simplified of late, and much of its complexity has been abandoned, still all the details now required are practicable only in hospitals and in the homes of the more wealthy classes. Consequently, if country practitioners should encumber themselves with all the paraphernalia required, the environment of their patients in a large proportion of cases would render it useless. Admitting, then, that the doctrine is true as claimed, the strict rules of antiseptic practice can be followed by country practitioners only in a limited number of cases, as the subject is now understood.

I am not vain enough to undertake a thorough critical review of antiseptic surgery. A subject which has occupied so much space in all our medical journals for so many years must be sufficiently familiar to every physician in the country. And having no new facts to present, it would be a waste of time to reiterate that which is already known to everybody, even if I were competent to do so—which is by no means the case. But a few practical reflections on some of its more salient points may be allowable.

Inasmuch as great latitude has been taken in the consideration of antisepticism which includes all that is meant by antiseptic surgery, it may be well to define what is meant by the term as used in this paper. According to some, it is used to include not only all means used to destroy germs *in esse*, and to prevent their generation, but also to prevent infection from any and every other source. Perhaps but little fault can be found philologically with this definition. But practically it is not correct, and I would restrict it to a consideration of the means and methods proposed for the destruction and prevention of micro-organisms of all kinds, on the assumption that they are the specific causes, the actual, and active, and only pathogenetic agents in the several diseases in which they are found. The use of the term, as applied to means to prevent sepsis from any other source, is an afterthought, is not the construction intended by its originators. The term phrenology would imply, from its etymological construction, mental philosophy, or the science of the

mind in its broadest sense; but we all understand by that term, as it is commonly used, what has been vulgarly called "bumpology," or the art of telling the peculiarities of individuals by palpation of the head, or, if you please, cerebral localization. In a single word, then, I would define antisepticism, as applied to antiseptic surgery by modern writers and practitioners, as *Bacteriopathy*.

As all know, it is founded on the germ theory of disease, one of the most beautiful and plausible theories that was ever launched on the sea of medical philosophy. But it is another striking example of the tendency in our profession to seek for a principle before the facts upon which it is founded have been sufficiently investigated and established. Indeed, the medical profession has been dominated from time to time all through its history by theories which have received more or less general endorsement, some of which, when subjected to the crucial tests of time and experience, have been rejected as false *in toto*, while many of them, though containing many false facts, have developed some important scientific truths, and have contributed some real and useful precepts to the practice.

Cullen said: "There are more false facts than false theories in medicine." But when we take a retrospect of its history from the earliest days to the present time, we find much that is false in theory and in fact. Current medical literature has always abounded in chaff, from which it is often difficult, for the time being, to separate the grain. Leaving out the vagaries of homœopathy, allopathy, hydropathy, Thompsonianism, electicism, *et id genus omne*, we need only refer to the doctrines of the various schools from Pythagoras to the present time, and to the transient systems of practice based on them, which have held sway for a short season. They are too numerous and varied even to enumerate, but everybody can readily recall many examples. Medicine has been cursed in all ages by so-called discoveries, and many of the greatest minds in the profession in every age have been wasted in the vain pursuit and defense of some imaginary discovery. Paracelsus, a noted teacher of medicine in the 16th century, discovered the doctrine of Tartar, which he said was the cause of all diseases of accumulation, obstruction, and concretion. Thompson discovered that all diseases originate from cold, and that heat and heating remedies supply a perfect panacea. Hahnemann, the founder of homœopathy, discovered that all the maladies which afflict mankind, epidemic, sporadic, idiopathic, and symptomatic, spring from three original diseases, viz.: syphilis, sycosis, and the itch. His *similia similibus*, dilute potencies, and infinitesimal doses are therapeutical novelties worthy of his pathology. And now comes along the doctrine of the germ theory, which teaches that all diseases originate from specific germs or living organisms. We have the bacterium of suppuration, the bacillus of tuberculosis, the bacillus of syphilis, of hydrophobia, of cholera, of tetanus, the gonococcus of gonorrhœa, etc.

This beautiful theory supplies a desideratum in etiology long felt, and furnishes an easy solution to many problems which have greatly perplexed the profession for many generations. Immediately after its promulgation, the fertile mind of the discoverer, ever on the alert for something new, was set to work to find some means of killing these microbes, which, like the giants that peopled Don Quixote's brain, cause all the miseries and all the woes that afflict mankind. Antiseptic surgery, Minerva-like, sprang into existence in full panoply, and has carried the medical profession by storm, with all its boasted modern advancements. So strongly is it endorsed, that it is almost as much as any ordinary man's professional scalp is worth to express any doubts of its entire correctness. Carbolic acid long stood at the head of the list of germicides. Not only the hands and instruments of the surgeon, but all dressings, were required to be constantly wet with a solution of it, and the very atmosphere of the operating-room must be filled with its fumes. A complicated apparatus was required to generate the spray, which, however, proved to be so unhandy and so inconvenient that it was found to be unnecessary and has been abandoned by many operators. To say the least of it, it is possible that more lives have been lost by it than by the microbes it was intended to kill.

Without attempting to enumerate all or any of the minor agents recommended and used as germicides, I will only mention the latest, bichloride of mercury. This is all the fashion now, having supplanted carbolic acid to a very great extent. It is a most virulent poison, and to be at all safe it must be diluted to homœopathic proportions. Even then, if strong enough to be relied on as a germicide, it is not devoid of danger. Billroth says: "Corrosive sublimate in dilute solution is practically inert as an antiseptic application to wounds, and

renders the patient and surgeon alike liable to mercurial poisoning. Carbolic acid, known to be dangerous in strong solution, is in very weak ones as good for wound irrigation as clean water, but probably no better."

We are not yet freed from the superstition and credulity which have always prevailed in our profession. We are still liable to be captivated and led astray by the plausible deductions and legitimate conclusions drawn from false premises by enthusiastic discoverers; and if we look with contempt and pity on the absurdities of the exploded doctrines of our predecessors, we doubtless shall meet the same fate from our successors. It yet remains to be proved that the discovery of bacteriopathy is any more true or practically useful than homœopathy or hydropathy. False and absurd as these latter may be in theory and in fact, nobody will deny that they have accomplished good results in practice. And if antisepticism in surgery should accomplish nothing more than to demonstrate the great advantages of absolute cleanliness, it will have accomplished incalculable good. It will not be the first instance in which exhaustive studies and experiments have been made in pursuit of a false theory, whereby grand results, not contemplated and not anticipated, have been accomplished. Astrology, diligently studied for many centuries, for the purpose of learning how to foretell and even to control future events, led to the grand and beautiful results of astronomy; and alchemy, which engaged the minds and the life-time studies of the greatest philosophers of the world, whose object was to find out the secret of converting the baser metals into gold and silver, and to discover the elixir of life or the art of preserving human life indefinitely, resulted in the splendid achievements of modern chemistry. I would not, therefore, underrate the labors and investigations of such men as Pasteur, Koch, Klebs, Cohn, Cohnheim, Virchow, Tyndall, and others in Europe and America, engaged in similar studies. I confidently expect important results from their labors, whether the germ theory be established or not. But any system of practice founded on a theory not yet proved to be true is premature, and is destined to be severely pruned, if not entirely discarded, by the inexorable hand of time. Whatever of truth there may be in it, of course, will stand the tests of time; but the errors will be relegated to the limbo of their predecessors.

The frequent presence of bacteria or other micro-organisms in disease-processes, is generally admitted, and seems to be easily demonstrated. But their functions, or their relations to those processes as cause or effect, are not established and do not seem likely to be soon. Opposed to the theory of their agency as etiological factors, we have the hypothetical doctrine of their incidental or accidental presence as natural scavengers for the consumption of effete matter. The extreme minuteness of these bodies, requiring the most powerful microscopes for their investigation, as well as the great liability to optical illusions, makes it so difficult to understand their true relation to their surroundings, and to define their exact agency in disease, that we should be very slow to found upon their presence any theory, or any system of practice, calculated to revolutionize the established methods of many centuries.

Bacteria or micrococci have been found in great quantities on the mucous membranes, in the blood, and in the fecal discharges of healthy persons. They have been found under Lister's antiseptic dressings without suppuration following. It is asserted furthermore, by high authority, that suppuration can be produced without the presence of minute organisms of any kind. The bacillus of tuberculosis, from the discovery of which we were induced to hope so much, has been found under such varying circumstances, that nothing practical seems likely to result from it. The same may be said of all the rest, except perhaps the bacillus of anthrax, which alone seems to have met all the requirements of mycologists, as a specific and demonstrable cause of disease. In the case of all the others the conclusion is merely from analogy. It is claimed that a septic liquid may retain its poisonous qualities after all microbes have been destroyed in it, and it seems to be proved by experiments that septic poisoning can be produced in animals by the products of organic decomposition without the presence of living organisms. It is claimed that bacteria become most numerous in materials of a septic or infectious character, after the period of their toxic intensity has passed by. Wherefore it may be assumed with equal authority, that all the effects usually attributed to disease germs may be caused by the toxic action of the soil in which they have existed, whether it is membrane, urine, blood, virus, artificial culture material, or anything else.

In this connection the pathogenetic agency of ptomaines and leucomaines should be

duly considered. But I do not propose to consume any time with that subject, although it is now engaging, in its investigation, some of the ablest chemists and biologists in the world. If the researches of Gautier, of Brieger and others engaged in its study, should verify their etiological importance, and if the claims of bacteriologists should be established, our profession will be completely revolutionized, and all our present systems of etiology, pathology, and therapeutics will be supplanted. But however much we may boast of our superior attainments and enlightenment, it is not at all probable that we are so far superior to our ancestors as to warrant any such expectations. It is a fact, I believe, that every generation has considered itself much smarter than its predecessors, but yet we find "that history merely repeats itself."

But I have already extended the limits and scope of this paper beyond what was intended when I commenced writing, and I will conclude with a few practical suggestions for the benefit of my country brethren. It is a fact undenied, and probably undeniable, that the mortality from wounds and surgical operations, especially in hospital practice, has been greatly reduced since the introduction of antisepticism. But it is a significant fact, that the very highest degree of success has been achieved by surgeons who do not use the antiseptic methods. And this is not due to accidental or fortuitous circumstances. Surgeons of equal qualifications have operated at the same time, in the same hospitals, one with and the other without all the rules of antisepticism, with equal success. I venture the assertion, that the qualified general or country practitioner who uses no antiseptics *per se*, can boast a degree of success equal to that of the most distinguished specialist with all the antiseptic appliances most rigidly enforced. I will not consume time in an attempt to enumerate the causes of this, or the causes of the great decrease in mortality, not the least of which is the increased importance attached to cleanliness, and to minute details in operations and in treatment. Ever since the Mosaic laws were promulgated, filth as a factor in disease has been more or less appreciated in all civilized countries. But never has this appreciation taken such practical shape as it has done within the last few years. The fact is established and admitted by everybody; but like many other facts in medicine, it is empirical, its *modus operandi* is not as yet understood. Great harm has been done to the profession by the crude philosophy and hasty conclusions of pseudo-scientists, which constitute the great bulk of our literature on this subject. It matters not how distinguished the writers may be, and it matters not how plausible their reasoning may be; if it is not based on original research, and on premises well established, their conclusions are not reliable. They may be familiar with the microscope, and they may be able to focus micro-organisms, and yet not be reliable. Very few men in the world are qualified to give authoritative opinions on this subject, and such men are about the last to promulgate a dogmatic declaration on this or any other subject. No amount of study and speculation on other men's labors can settle any question until all the basic facts have been clearly evolved and established. I would therefore caution my country brethren, and all general practitioners, who are practical, if anything, to beware of hasty and imperfect conclusions. Wait until all doubts and uncertainties have been removed by those who alone can do it. Avoid the growing spirit of reckless experimentation. In the meantime, let us stick to those means and methods which have given success to our fathers, and which have enabled us to achieve results which we can compare with pride and confidence with the best of them. I would not reject anything because it is new, but I would not adopt it merely because it is plausible.

FRACTURES OF THE FOREARM.[1]

BY JOHN BROWNRIGG, M.D.,
COLUMBUS, MISS.

Believing that we have not attained a perfect method of treating the most common fractures of the forearm, I present for your consideration some new appliances which have been used with good results. In these fractures it is best to prevent flexion, extension, pronation and supination of the forearm. It is also necessary to keep the forearm splints parallel to each other transversely and longitudinally. Collis's and Barton's fractures require a different appliance, which will be described separately.

Fractures Above the Lower Third.

The roller bandage has done so much harm in unskillful hands that I have abandoned its use except on the hand. With the

[1] Read at the meeting of the Southern Surgical and Gynecological Association, at Birmingham, Ala., Dec., 1888.

elbow flexed at a right angle, the inside splint should be a little wider than the forearm, and long enough to extend from behind the elbow to the metacarpo-phalangeal articulation. The outside splint should be of the same width, and long enough to extend from behind the elbow to near the styloid process of the ulna, and should be cut out under the thumb. Two pieces, of the same thickness as the splints and one inch wide, should be shouldered into the outside and inside forearm splints so as to present a plane surface with them, and secured to the splints with little nails, so that these pieces will be at right angles with the splints, and opposite the axis of the arm, and long enough to extend up the arm to below the prominence of the deltoid muscle. To these inch-wide pieces are tacked, next to the arm and above the elbow, two bands of tarboard, wide enough together to envelop the arm and meet above the forearm at the elbow as flexed, and extending upward as high as the inch-wide pieces. If higher, they will be pushed down by the prominence of the deltoid muscle, and the splints with them, so that the bones will be bent at the point of fracture. The pieces of tarboard should be soaked in hot water, so as to be molded to fit the arm, and lined with cotton wadding and cloth next the skin.

The forearm splints should be cut an inch longer than necessary, and, after the tarboard bands are tacked on, apply the splints, and mold the tarboard bands to fit the arm, and then cut the lower end of the splints off, the right length.

The forearm splints should be notched on their outer edges, to keep the strips of cloth to be tied around them from slipping. Strips of cotton wadding should then be laid on the side of the splints next the arm so as to fit the arm, in some places thick, in others thin, and a piece of cloth sewed around the cotton wadding and splints, drawn so tight as to cause the cotton wadding and cloth covering to present a slightly convex surface, as used by the late Dr. F. H. Hamilton on his forearm splints. Too much convexity is not desirable, as the bones may be pushed too far apart, particularly if the strips of cloth are tied too tight around them. There should be but little cotton under the hand and at the elbow.

When the bones are from any cause disposed to separate too far, a many-tailed bandage, applied at the point of separation and extending to the hand, will prevent it. Apply a narrow roller bandage to the hand from the wrist to near the end of the fingers, apply the splints, and, if they fit, bind them on with a few strips of cotton cloth, tied around the arm and forearm parts, so as to exercise gentle pressure. These strips can be loosened or tightened by anyone as the arm swells or shrinks. These convex pads serve well to keep the bones apart, but caution is required in their use, as by binding them too tight the bones may be forced too wide apart or pressed out of position.

When the ulna is broken near its middle, the upper fragment is sometimes drawn away from, and the lower toward, the radius, so as to cause a separation of the broken ends. It is at this point that ununited fracture often occurs. To prevent this, a strip of thin board, not quite so wide as the space between the lower edges of the forearm splints when applied, should be padded with cotton and rolled in cotton cloth and placed underneath the strips which bind the splints on, so as to keep the ulna straight. This thin board should be of the same length as the outside splint. The forearm should then be placed in a sling with thin strips of wood sewed in its upper edges.

In 1885 I read a paper before the Mississippi State Medical Association, describing two rectangular splints, which I had used in these fractures, before I had seen Dr. John H. Packard's account of the use of an internal rectangular splint.

Dr. Scott's rectangular splint prevents motion of the elbow, pronation and supination, but does not provide for keeping the bones apart, and the forearm is in a position of forced supination, which is very uncomfortable. Finding the straight rectangular splints disposed to slip down, I adopted those described above. Very moderate pressure is required, and it is difficult to displace them. A many-tailed bandage should be tied around the hand and splint to keep the hand up.

Barton's or Collis's Fracture.

All the fractures at the lower end of the radius, whether transverse or comminuted, or the oblique fracture first described by Dr. Barton, require extension and counter-extension. These cannot be obtained by using the hand as a lever and the lower end of the ulna as a fulcrum, even when its semi-articulation with the carpus is not destroyed. The displaced fragments cannot be forced into position and kept there by coaptation splints, and if this could be accomplished, the amount of pressure required leaves the wrist and hand stiffened. Fractures near a joint almost always leave the joint stiffened

unless early motion is resorted to. This inflammation is almost certain to attack the articulations of the carpus. Internal and external coaptation splints, no matter how shaped, prevent motion, and more or less pressure on the carpus is necessary. It is important to preserve the proper position of the lower end of the ulna in relation to the carpus. The cause of the loss of prominence of the styloid process of the ulna is due to the twisting of the carpus with the fragment of the radius attached inward, and it is also drawn to the radial side of the forearm by the contraction of the muscles attached to the hand. This displacement of the lower end of the ulna is more marked when its semi-articulation with the carpus is destroyed. The contraction of the muscles causing this displacement should be resisted by extension and counter-extension. If one grasps the hand and twists it forcibly inward a good idea can be formed of the manner in which this displacement occurs. If the muscles of the forearm are resisted by extension and counter-extension in the direction of the axis of the radius, there will be a tendency to readjustment of the fragments, and with very little lateral support this can be accomplished. For this purpose I use a splint composed of an iron bar, sufficiently strong to prevent motion of the elbow, and to keep it flexed at a right angle. The bar extends from below the prominence of the deltoid muscle to the elbow, where it is bent so as not to press on the elbow, thence along the radial side of the forearm, which is between pronation and supination, the thumb being upward; to beyond the end of the first phalanges, the hand being flexed, where it is bent downward at a right angle about three inches. Where the bar passes over the thumb, it is bent upward so as not to press on it. In front of the arm a tarboard splint or band is riveted to the bar, wide enough to extend from the top of the bar to near the forearm, and long enough nearly to envelop the arm.

To the forearm part of this bar is secured a similar tarboard splint, by two strips of sheet iron, riveted to the tarboard splint and bent loosely over the iron bar, so that the splint can be made to slide up or down on the bar. This tarboard splint should be as wide as the forearm on its inside, and a little over half as wide on the outside of the forearm, care being taken that it is not wide enough to press on the styloid process of the ulna nor on the ulna. It should be long enough to extend from near the elbow to the lower end of the radius. The hand should be flexed loosely, the ends of the first, second, and third fingers resting easily on the ball of the thumb. A roller bandage about an inch and a half wide should be passed around the wrist three times and the end stitched. A broad band should be stitched to the bandage around the wrist on the back of the hand, and carried around the flexed fingers and stitched to the bandage on the inside of the hand at the wrist, to retain the fingers in a flexed position. The object of this is to preserve the parallel position of the metacarpal bones, and to prevent their being folded inward upon each other by the extension band, described as follows: A belt cut bias to fit the hand near the carpus, and buckled securely, so as not to slip over the hand, is applied. Two rings of brass or other metal are sewed to the lower edge of this belt, one on the outside and the other on the inside of the hand. Extension is obtained by a cord passed first over the bent lower end of the bar, the ends being then passed through the rings and tied over the bent end of the bar. Counter-extension is obtained by the pressure of the tarboard splint against the arm above the elbow.

The tarboard splints should be lined with cotton wadding and cloth next the skin, and secured to the arm and forearm by many-tailed bandages, the ends being tied together. After the cord is tightened sufficiently, the forearm tarboard splint should be slipped on the bar toward the hand until the lower end reaches near the carpus, and can be made to act as a coaptation splint at the point of fracture, but only gentle pressure is required, the contraction of the forearm muscles causing the displacement being resisted by extension and counter-extension.

Sometimes a narrow roller bandage is required to keep the hand from swelling.

Constant slight motion of the carpus is permitted. When the splint is applied, the thumb should be under the iron bar. This can be secured by applying the belt around the hand so that the ring on the back of the hand will be near the thumb, and the one on the palmar side nearer the little finger. This causes the hand to be twisted outward, which is the reverse of the abnormal position resulting from the fracture.

If greater lateral pressure should be required, it can be obtained by two pieces of thin board placed transversely opposite the point of fracture, one inside and the

other outside the forearm, the ends projecting a little so that cords can be tied around them below and above the forearm. These pieces will press as required on the tarboard splint. I have only had to resort to this in a case of ununited fracture of eight weeks' standing.

THE PREVENTION OF CONCEPTION.

BY H. B. RUNNALLS, M.R.C.S., L.S.A. (ENG.),
BEDFORD, PA.

I have read with interest the various papers which have appeared in the REPORTER, upon this subject, and I believe that, if it is discussed upon purely scientific grounds, nothing but good can result from it, both for the public and the profession; but if it is written upon with a view to providing means for preventing conception, from pecuniary or social motives, then, in my opinion, it would be well to allow the matter to drop. Long ago I thought, and I still think, that the law should make it a "criminal act" for members of either sex, suffering from constitutional diseases which might be transmitted to their offspring, to indulge in sexual intercourse; for the effect of such intercourse is usually to reduce the physical standard of a nation, and to produce a population to whom life is a misery. It would be well, perhaps, if the law forbade marriage unless the parties concerned were, first of all, examined by medical experts. That there are cases which come under this notice, in which, after marriage or after the birth of children, means to prevent conception should be adopted, I am prepared to grant; and in these cases, it should only be suggested after the reasons for such had been explained. I would always advise it where puerperal or uræmic convulsions accompanied pregnancy; where vomiting was severe during pregnancy; where any pelvic deformity existed, or any uterine or ovarian growth was present; where excessive hemorrhage accompanied labor; where the perineum or other parts had been lacerated much during labor; where any hernia of the intestines was present; and where any heart, kidney or lung mischief was present—in fact, in all cases in which the medical attendant was of the opinion that evil results would follow conception; but never merely for social or economic reasons.

Wherein lies the difference between prevention of conception and the production of abortion? It does not much matter whether it is the spermatozoid or the fœtus that is destroyed, the fact is the same. For those whose moral sense has reached such a low standard, the charlatan has already provided the "French letter" and other means; but I hope the day will be far distant when our profession recognizes such practice except for physical reasons.

ASEPTIC NEEDLE-FORCEPS.

BY A. ADY, M.D.,
MUSCATINE, IOWA.

The instrument represented by the engraving will hold any kind of needle—round, flat, straight or curved—and hold it firmly. It has both a diagonal and rectangular slot. In these days of antiseptics, all surgical appliances should be as free as possible from any danger of carrying septic material from one case to another; and any instrument

that can not be readily taken apart for the purpose of cleansing is consequently dangerous. This holder was invented with special reference to the avoidance of any such danger. Being practically composed of only four pieces, it can be taken apart instantly by removing the nut, and cleansed and as readily put together again. I find it a very handy instrument, especially in gynecological operations.

SOCIETY REPORTS.

ITALIAN SOCIETY OF INTERNAL MEDICINE.

FIRST CONGRESS, AT ROME, OCT. 20 TO OCT. 24, 1888.

(*Concluded from p.* 688.)

Monday, October 22.

PROF. CARDARELLI, of Naples, read a paper on the

Treatment of Heart Disease,

in which he said that the first symptom which indicates some kind of organic disturbance of the heart muscle is the increase of the intra-cardiac pressure; this increase produces a slowing of the cardiac rhythm by a stimulation of the peripheral filaments of the pneumogastric nerve; the slowing of the cardiac pulsations produces a great accumulation of blood in the organ, and this prolonged diastole must be followed by a more vigorous systole—hypersystole, as it has been called. If the muscular fibres of the heart are in an abnormal condition, if the nervous apparatus is out of order, the heart cannot resist such an increase of pressure, and, consequently, hypertrophy and dilatation of the cardiac muscle take place. The physician must then at this moment do all he can to sustain the nutrition of the cardiac muscle, and prevent any abnormal activity of it. If the heart continues to find a resistance, it will employ all its latent force; but after a while this will be insufficient, and then the symptoms of cardiac asystole make their appearance. To measure the force of the cardiac muscle, Dr. Cardarelli places a tourniquet on both femoral arteries, and records the sphygmographic tracings. If the latent force of the heart is a feeble one, there will be observed, following the compression of the arteries, a great disturbance of the circulation. If the heart is unable to resist the increased vascular pressure, blood-letting must be resorted to. No alarm should be felt at the depression which sometimes follows it. If the heart is found to be only fatigued, the drugs can be used which are stimulants of the cardiac contractions; but it must not be forgotten that the natural stimulant of the heart is stimulus of the intra-cardiac pressure.

As to the nervous affections of the heart, one must find out whether they are due to trouble with the pneumogastric nerve or with the great sympathetic. To know whether the cause of the disease is an excitation or paralysis of the pneumogastric nerve, the modification of the cardiac rhythm as produced by the pressure of the finger on the nerve trunk in the cervical region must be studied. The liver and stomach must also be carefully examined, as they often are the point of origin of the reflex.

PROF. DE GIOVANNI, of Padua, referred to the discussions which have lately taken place in Germany, in regard to the method of Oertel; Dr. de Giovanni does not think himself that all cardiac patients should be condemned to a forced rest; but still he does not think that such patients should be allowed to take the violent exercises recommended by Oertel; these should be allowed only when the heart is sufficiently resistant to stand the pressure. As a test of the resisting power of the heart Dr. de Giovanni employs hypodermic injections of strychnia, which by producing a contraction of the capillaries interferes with the peripheral circulation; if the heart is able to resist this interference of the circulation, physical exercises may be recommended. This resisting power could be measured by giving gradually increasing doses of strychnia; in this manner the amount of physical exercise which the patient could stand could be regulated. He also employs as a test the elastic bandage of both lower extremities; but this test is a very severe one for patients whose cardiac muscle is severely involved.

PROF. RUMMO detailed the treatment of cardiac diseases with medicines. He insists on the necessity of maintaining the activity of the cardiac muscle on a plane with the resistance which the heart has to overcome; he divides the cardiac drugs into three groups: First, Those that act directly on the myocardium, producing an increase in its contraction; they are: Strophanthine and helleborine. Second, Those that act specially on the muscle and cardiac innervation: Upas antiar, digitalis, erythrophleine, rose laurel (Nerium Oleander). Third, Those that act equally on the heart and its innervation: adonidine and convallamarine.

PROF. MURRI, of Bologna, read a paper on

Fever and Antipyretics,

in which he said that as a result of his experiments he had come to regard fever as only a symptom of the disease which produces it, and not as of nervous origin. He has demonstrated this by extirpating the brain in pigeons and then injecting toxic subtances into their body. He found there

was a certain rise of temperature; the same elevation of temperature he obtained when he injected similar substances into the body of animals which had been dead from two to eight hours, by which time the nervous system had lost its activity. He does not think that the nerve centers regulate the loss of animal heat; for he passed a certain amount of warm water into the stomach and intestines of dogs, leaving in place the lungs and skin, which are the great surfaces by which heat is withdrawn from the body; and yet he obtained a persistent rise of temperature.

He is opposed to the use of antipyretic remedies, on the ground that fever is only a symptom of the disease and not a cause of it; moreover, he thinks that by allowing the fever to remain, the development of certain microbes is prevented, and in some cases that they are even destroyed.

Prof. Maragliano, of Genoa, does not think that fever can in any way destroy the pathogenous microbes, for Dr. Gaffky has proved that Fränkel's diplococcus resists a temperature of 107° F., and the typhoid fever bacillus a temperature of 106° to 107° F. He mentions the fact that soldiers who have made a forced march are sometimes found to have a temperature of 106° F.; without having been previously infected they yet present the symptoms of typhoid fever. This proves that an elevation of temperature is by itself sometimes a cause of disease; and he thinks that in infectious diseases the morbid phenomena observed are due to the fever, and hence must be combated by the proper antipyretic remedies.

Prof. Bozzolo, of Turin, does not think that antipyretics should be done away with, although he agrees with Prof. Murri as regards the influence of pathogenous germs in the production of fever.

Dr. Cantani, of Naples, also thinks that the existence of fever can prevent the development of certain microbes, and in the fever he only finds a reaction of the body against the morbid germs and their products. Instead of using the medicinal antipyretics, which act by diminishing the vital reaction, he prefers to employ such agents as aerations, cold baths, and the ordinary hygienic precautions.

Dr. A. Bianchi read a paper on

Tumefaction of the Spleen in Syphilis.

He has observed a very interesting fact, that the spleen increases in size in every case of syphilis, and assumes a pear-shape, the base of it directed downward. He found that this increase of size of the spleen begins with the appearance of the primitive chancre, attaining its maximum in the second stage of the disease. The mercurial treatment produces a diminution in the size of this organ.

Tuesday, October 23.

Prof. Cantani read a paper on the

Etiology and Treatment of Diabetes,

in which he defined diabetes as a general disease having its localization in the chylopoietic organs. The diminution of carbonic acid gas in the organism of the diabetic patient is a result and not a cause of the morbid process; it is consequent upon the diminution of the oxydation of hydrocarbons. The cause of diabetes he attributes to the too great use of farinaceous and sweet substances; in only rare cases does he think the disease is of nervous origin, and then it is only of a transitory character.

Having treated over one thousand diabetic patients, he finds that the best treatment is the complete suppression of the use of meat; if this is not done in a very strict manner, the sugar will rapidly appear again in the urine. He recommends the use of alkaline lactates, albuminous and fatty food, and alkaline waters, but rejects all the different preparations of bread, as well as medicinal treatment. He considers the cure a final one only when the patient can eat any food without any sugar appearing in the urine.

Prof. Cardarelli, of Naples, thinks that diabetes of nervous origin is more frequent than Dr. Cantani supposes; he has observed two cases in which a traumatism produced the presence of sugar in the urine; he has also observed that diabetes often precedes meningitis, especially in children. The treatment followed in cases of nervous diabetes is the absolute avoidance of meat as food, and this with excellent results.

Prof. de Renzi, of Naples, when he was at Genoa, observed that diabetes was extremely rare; he only met with one or two cases of the disease each year in his wards, and yet the inhabitants of Genoa are great meat eaters. While in Naples, where he now practises, the inhabitants almost altogether live on farinaceous and vegetable substances, and he meets every year in his wards with about forty to fifty diabetic patients. He also thinks that diabetes can have a nervous origin; sudden fright may

produce it. The treatment does not consist in the absolute exclusion of meat; but he allows his patients a certain quantity of it, combined with green vegetables and some wine. Prof. Maragliano does not pay great attention to the quantity of sugar contained in the urine; he watches his patient in regard to his weight; if a rapid decrease in weight occurs, he tries to sustain the patient's general nutrition as much as possible, and gives him a mixed diet, not excluding meat absolutely. He also adds milk and the preparations of strychnia.

Prof. Rummo thinks that some of the cases of diabetes which have been attributed to a nervous origin are due to the fact that primary disease had involved the nervous system early, and that the patient at the time of examination presented nervous symptoms, which made the physician think he had to deal with a case of nervous diabetes.

Prof. Baccelli, of Rome, says that in 1863 he presented the case of a young man who suffered from cerebral concussion after a fall, and died diabetic several years after; and at the post-mortem a cicatrix was found at the centre of the pons Varolii; in this case the nervous origin is unquestionable. In the puerperal states and in pregnancy, glycosuria of nervous origin is often observed.

Prof. Baccelli, of Rome, read a paper on the

Treatment of Hydatid Cyst,

in which he stated that he uses the following method: great antiseptic precautions being taken, about two and one-half drachms of liquid are taken out of the cyst with the hypodermic syringe, and an equal quantity of a solution containing from one-fifth to one grain of corrosive sublimate is injected in its place. The results have been most satisfactory; cure is obtained in about five days, during which time a slight febrile reaction is observed, but the liver returns to its normal form in about that time.

Wednesday, October 24.

Prof. Marchiafava, of Rome, read a paper on the

Plasmodium of Malaria.

He mentions the fact that during the former years only black pigment was observed in the blood of malarial patients, either free or included between the cellular elements; and it was thought to be a residue of the destruction of the coloring matter of the red blood corpuscles. He recalls the fact that for the first time in 1878, he discovered the change of hemoglobine into melanine in the interior of the red blood corpuscles, but never was able to explain this transformation. After the studies made in Algeria by Laveran, and afterward at the Anatomico-Pathological Institute of Rome, he thinks the following conclusion in regard to the destruction of the red blood corpuscles in malarial infection may be reached:

Certain microörganisms penetrate, under one form or another unknown to us, into the system by the inspired air, and from the lungs into the blood; in this last medium, these parasites invade especially the red blood corpuscles, and are found in the early stages as a protoplasmic form endowed with very active amœboid movements; they increase in size within the red blood corpuscle, and live at the expense of its coloring matter, changing this last into pigmentary deposits. These amœboid forms multiply by fission, and then invade new blood corpuscles, and this process continues.

The malarial parasite (*plasmodium malariæ*) is always in the early stages intraglobular, but later it presents itself under different forms. This plasmodium is the type of the intra-cellular parasite, and yet, although not a bacterium, it will produce a general infectious disease. In a doubtful case of malaria, the examination of the blood of the patient will settle the diagnosis. The malarial parasite lives altogether in the blood, and develops, multiplies, and dies in the red blood corpuscle. This parasite might die spontaneously, when a disappearance of the disease is observed; or, again, quinine may have a very marked effect in causing its destruction; but in any way the organism does not come out of the blood, unless taken out by blood-letting. This fact explains the non-contagious character of the disease; should blood of a malarial patient be injected into another man's blood-vessels a case of malaria would certainly be observed.

Dr. Mosso, of Turin, thinks that additional experiments are necessary to sustain the views expressed by Dr. Marchiafava. During his own researches, he has observed, while studying the blood corpuscles under invasion of the so-called parasite, that the protoplasm first becomes transparent, and afterward separates itself from the blood corpuscle. The same fact had been observed by Gaule some years ago, when, by acting on the frog's red blood corpuscles with a

solution of chloride of sodium, he observed that something came out of this corpuscle, and he thought he had to deal with a parasite, whereas, on the contrary, it was only a mass of protoplasm. The same changes Dr. Mosso himself has observed in the blood taken out of the human body; hence, he thinks that Dr. Marchiafava's plasmodium will be proved to exist only if he can prove that these forms are not the result of a degeneration of the cells, following their death; this so-called parasite must also be demonstrated as really penetrating into the red blood corpuscles.

Dr. Maragliano has also observed the changes described by Dr. Mosso as taking place in the red blood corpuscle; but he thinks they can be differentiated from the parasite by the fact that parasites have more regular contours.

Prof. Ferrati, of Catania, read a paper on

Puncture of the Spleen

for chronic tumors of this organ, of malarial origin. He has employed puncture of the spleen in many cases, with excellent results; in a person whose spleen measured sixteen inches in length and eight and two-tenths inches in breadth, the introduction of the needle three times produced a decrease of the tumor, of three fingers' breadth in length, and two in the transverse diameter. The experimenter was led to this method by a desire to know whether or not in the parenchymatous injections of certain liquids the introduction of the needle itself is the real cause of the amelioration.

Prof. Fazio, of Naples, read a paper on

Parenchymatous Injections of Quinine in Chronic Tumors of the Spleen.

He thinks these intraparenchymatous injections of quinine are more useful than puncture alone, as they combine both treatments.

Prof. Baccelli read a paper on the

Treatment of Neuralgia by the Hypodermic Injections of Carbolic Acid.

He injects a solution of one per cent. of carbolic acid into the painful part; he has obtained very good results, especially in cases of supraorbital, intercostal, and ischiatic neuralgias, and also in the articular pains of chronic rheumatism. This same treatment he has used in a case of tetanus, injecting the substance every hour; he used at first one-fifth grain of carbolic acid for each injection, then two-fifths grain. The spasms disappeared gradually, and the patient was well in eight days.

Dr. Sonsino, of Pisa, read a paper on the

Treatment of Ankylostomasia with Thymol,

in which he said he had to treat, some time ago, a young woman about 18 years old; she was anemic, had amenorrhœa, was not well developed for her age; she said that while in the country she drank water from a certain river. Iron was given her without success; examining the fæces finally by the aid of the microscope, he found he had to deal with a case of ankylostomasia; thymol was given her in repeated doses of sixty grains, and she evacuated about one hundred and thirty of the parasites. A few days later, the renewal of the treatment produced the evacuation of seventy more. The patient took twenty-three grammes (six drachms) of thymol in all. He recommends, in cases of intractable chlorosis, to search for the eggs of ankylostomata.

Before separating, the Congress selected Rome as the permanent place of reunion. The next meeting of the Congress is to be held in 1890; Prof. Baccelli, of Rome, will be President.

Reports of Clinics.

COLLEGE OF PHYSICIANS AND SURGEONS—VANDERBILT. CLINIC.

MEDICAL CLINIC—PROF. DELAFIELD.

Pleurisy with Effusion.

The patient was a man, 26 years old, who has been sick two weeks, his illness beginning with a "stitch" in the right side low down in the axillary line. The pain continued, and was felt also in the front of the chest. Dyspnœa was also complained of.

He was well in every other respect—no headache, no vomiting, bowels regular, and appetite good. His temperature, when he first presented himself at the Clinic some days ago, was 101°; to-day it is 99.8°.

Examination shows the patient to be somewhat emaciated; his chest has the characteristic shape seen in emphysema of the lungs, that is, a bulging of the costal cartilages on each side of the sternum. The percussion note over the upper part of the chest in front has a different quality from that of the normal pulmonary resonance. The respiratory murmur is less distinct on the right side than it should be; on the left side it is good. The apex of the heart is in

normal position, and there is no murmur. Posteriorly the left side shows nothing abnormal. On the right side there is dulness from the middle of the scapula to its angle, and below this there is flatness. The breathing and the voice are heard to the line of the flatness. This, then, is a straightforward case of pleurisy with effusion. It illustrates well the slight effect this disease may have upon a patient. The man suffers now only from slight pain and some shortness of breath, and says he feels well able to go to work. It is easy to see how practitioners can overlook such a case; the symptoms being so slight they neglect to make a physical examination of the chest.

When this man first came under treatment the fluid reached to the middle of the scapula; now its limit is marked by the line of flatness and loss of respiratory murmur and voice on auscultation. This is a very good result, and it has been obtained by rest, the application of iodine to the chest, and the administration of a simple cough-mixture—really no treatment.

And yet rest is the most important element in the cure of these cases. Allow this patient to go to work, to expose himself to changes in the weather, etc., and in a few days his chest would be found half-full of fluid. But keep him at rest until the fluid has all disappeared and the patient has felt himself well for some little while, and a permanent cure will be obtained in the shortest time.

Dilatation of Stomach (?)

This patient was a man, 23 years old, a shoemaker by occupation. His work is not heavy; he has very little stooping to do; he does not press anything against his chest while at work. He has been sick one year, and complains of dull pain in the right side just below the free border of the ribs. It comes and goes. He has never felt it at night. At first it would appear only occasionally, and he might go two or three days without it; but latterly it has been growing worse, so that he has it now almost every day. In some weeks he has a respite, but in others the pain remains all the time. The patient does not complain in any other way; his appetite is good, his bowels regular, and he attends to his work. The urine shows a specific gravity of 1022; it is alkaline in reaction and does not contain albumin. Examination reveals nothing abnormal about either lungs or heart. The liver is normal in size and position. There is a fullness noted in the epigastric region, and on kneading this a distinct splashing sound is heard. But this man says he has eaten his lunch only two hours ago, and the knowledge of his coming here may have produced sufficient excitement to retard digestion. His stomach at present is full and dilated. But is this a pathological or a physiological dilatation? It is very common, at the present time, to make a diagnosis of dilatation of the stomach on imperfect data. To be pathological the dilatation must exist during the greater part of the time. In the present instance, having never seen this patient before, it would be impossible to make a positive diagnosis. If his stomach were at all times as large as it is now, it would certainly be dilated. In this patient there is simply a history of pain; and the character of the pain is such as to incline one to exclude organic disease. On examination we are able to add only two facts to this history, namely, the dilatation of the stomach and the alkalinity of the urine. This man has not been taking medicine to produce such an effect, and in a young man we do not expect to find alkaline urine. These three facts, therefore, point to *some* disturbance of digestion. The character of the pains—wherever they may be situated—are quite pathognomic of such a state; but our history does not cover a period long enough to make a positive diagnosis.

We shall instruct this patient to return next Thursday. During the week he will be allowed only one solid meal a day, and that to consist of meat and potatoes alone. For the rest, he may drink milk. He shall come to us without having previously eaten for three hours. We will then test his stomach contents, which will be removed with the stomach pump.

Chronic Endarteritis.

This patient was also a man; he was 65 years old, a native of Ireland, and a laborer by occupation. He has suffered for the past twelve years with attacks of unconsciousness, which come on suddenly so that he usually falls to the ground without having any premonition of their appearance. They last usually about fifteen minutes, and leave him without palsy or other sign except headache, so that he can return to work in one hour after the attack.

Sometimes the attacks are more severe. They have increased in severity as well as in frequency lately, so that he has had four during the last five weeks; two attacks occurred on last Wednesday. The patient has not worked for the past six months, though

he is able to work. He complains quite constantly of "tightness of head" and failing memory—though he is able to apply his mind; and also of very poor appetite; his bowels are somewhat constipated. There is no sleepiness during the day, and he sleeps well at night; there is no vomiting. On only one occasion were there noticed twitchings of the right side of the face; he has never had any other convulsive movements.

His urine has a sp. gr. of 1004, and contains no albumin. Examination shows the tension of the radial arteries to be decidedly increased; they are not large and not tortuous. The lungs show evidence of emphysema. The heart's action is feeble in proportion to the arterial tension. It is not rapid, and is regular; there is no murmur.

This patient represents a class of cases which is difficult and even uncertain of diagnosis. We are usually satisfied with a probable diagnosis. The man does not look ill, though he has been sick twelve years.

What is the matter with him? [The students suggested many diagnoses; tumor of the brain and chronic pachymeningitis—both of which Dr. Delafield remarked were possible; chronic Bright's disease—which he had no doubt the patient suffered from, but which would not account for his attacks; cerebral anæmia and cerebral congestion—which he styled loose talking; and chronic endarteritis of the cerebral arteries. The last was the correct diagnosis.]

Continuing his remarks, Dr. Delafield said: These cases are not so very uncommon. But how can the fact be explained that the man has been sick so long and looks so well, and yet is suffering from endarteritis? We suppose the same happens here as so often happens in cases of cancer of the stomach. How frequently such a patient is heard to declare that he has been complaining of his stomach symptoms for five years, whereas his cancer has existed but two years, and previous to this time he suffered from dyspepsia.

This man's urine, pulse, and heart-action point to endarteritis; but he has not had it for twelve years.

His first attacks were, in all probability, simply vertigo—of bad form to be sure, but such as are frequently associated with derangements of liver and stomach. Later on, the attacks became associated with true unconsciousness. The patient himself does not note this change in the character of his attacks; he simply sees their increase in severity.

FOREIGN CORRESPONDENCE.

JOTTINGS FROM AROUND THE WORLD.

The Melbourne Hospital.—"Consultation Day."—Haphazard Teaching.—Rules Governing Hospital Pupils.—How Nurses are Encouraged.—A Clinical Lecture.

MELBOURNE, Oct. 1, 1888.

Since my last letter I have made a visit to the Melbourne Hospital. The medical superintendent, Dr. Lewellin, received me most kindly and made my visit interesting and profitable. The exterior of the building is not of an inviting appearance, and the wards within are decidedly old-fashioned. The hospital was founded in 1845; no conception of the future of Melbourne was then held in mind, so that the plan of building and the space allowed were not the same as if the founders could have seen clearly forty years ahead. The result has been constant additions and changes, so that the total effect is not altogether artistic. The medical staff consists of eighteen physicians and surgeons. Here again, as in the case of the Children's Hospital which I reported in my last letter, a committee acts upon the proper cases for charity; in fact, in 1864 an enactment passed the Victorian Parliament making it compulsory for each incorporated institution to be governed by a committee of not less than seven members, to be elected by the contributors. Even in emergency cases the committee allows to those who are able to pay only the most temporary assistance. My first visit was on Tuesday, which proved to be the regular consultation day, as it is called. On this day all new cases for operation are consulted on, a plan of procedure marked out, and the day of operation settled; the result of the consultation is entered in the consultation book, and the medical officers present attach their signatures to the statement. No important operation is performed without a consultation of this kind, and all such operations are performed only on Mondays and Thursdays, at 2.30 P.M. No operation is permitted on Sunday. This hospital is the chief source of clinical teaching for the University students, and on a closer examination of the clinical teaching here, I can but repeat what has already been said on this subject—that clinical teaching is very far inferior to our own in America. There is much haphazard teaching; there seems to be no system; to me it seemed to be in chaos. The remark was overheard: "What are you going to lecture

upon to-morrow, Doctor?" "Oh! let me see," was the answer; "do I lecture to-morrow? Oh, well, I will scare up something from the wards in the morning when I come, and I will give them something or the other." Passing into one of the wards I found bedside instruction going on; about thirty boys were collected about one bed; it was impossible for the most of them to see or even to hear. Poor hungry boys! The pathologist of the hospital is Prof. Allen of the University, of whom I spoke lately. In this particular the University is well served, as Prof. Allen has now the right to take all his specimens to the University, and to use them in class demonstration.

The rules governing the hospital pupils are of interest: after denying them free run of the wards without an officer of the institution, and assigning the exact hours at which they may be in the wards at all, a further useful rule is that they must not enter any ward on the same day on which they may have been in the dead-house, or present at a post-mortem examination, whether at the hospital or elsewhere; this is doubly insisted upon as regards entry into a surgical ward. At the commencement of each term of attendance a pupil must put himself under the charge of some physician or surgeon, and continue with him during the whole of that term. Before the commencement of every term of attendance, each pupil must pay to the Secretary of the Hospital the following sums, in addition to the fees charged by the University for attendance on clinical lectures: (1) For the use of the hospital, twenty-five dollars; (2) for the pathologist, six months, eleven dollars; (3) for use of the dispenser, sixteen dollars, each three months; (4) for the physician or surgeon whose practice the pupil attends, twenty-five dollars. Every hospital physician and every surgeon has two clerks or dressers, who are appointed from the medical students of the University by the medical superintendent, subject to the approval of the committee. These clerks are appointed for six months. I found the nurses here also well drilled, and of a superior character. The reason is evident: after two years' faithful service they have an increase in salary of twenty-five dollars per annum, and a further increase of five dollars per annum for each succeeding year of service, until the sum amounts to sixty-five dollars in excess of the original salary.

In the out-door department the one shilling fee for attendance is adhered to; this is the rule in all the charities in this city. Since the adoption of this rule, Dr. Lewellin says the service has been reduced greatly, which even now is too large, amounting on an average to sixty or seventy a day. Four separate funds are maintained, called respectively the maintenance, the building, the endowment, and the convalescent fund. The latter is interesting, being devoted to five objects, viz.: to defraying the expenses of patients going to the sea-side or to the country; to the purchase of clothing; to defraying the expenses of removing the patients to their homes; to supplying small sums of money to patients leaving, to assist in maintaining them until they are able to return to work; and to providing, partly at least, for the purchase of trusses and other instruments or appliances.

The hospital building is situated in the very heart of the city. Hearing that one of the clinical lectures was to be held the next day, at the appointed time I went and found Mr. Ryan in the arena. He is a genial man of about 40 years of age, and gave a clear lecture on cancer of the tongue, the text being supplied by a young woman who was thus affected. While the girl walked around, and a few general remarks were being passed concerning her, I took the opportunity to take in my surroundings. The amphitheatre was very small, three rows of seats for the students, of whom I counted just thirty-five present. The lecture must be compulsory, as the roll was called. This one case was all that was brought in. The opinion was given that the cancer of the tongue was the result of irritation of some rough teeth; the case had been seen some time before, when there was a true pre-cancerous ulceration, and the girl was then urged to have the teeth attended to, but after neglect she had come back in the condition mentioned. The lecturer insisted that very many cases of cancer of the tongue have their origin in some local irritation, such as teeth, or the improper use of caustics, etc. If there is need of caustics about the tongue, he would use a good one at once—the actual cautery or pernitrate of mercury. He thinks heredity plays very little part in the production of this kind of cancer. In his experience he has found secondary deposits in the internal organs very rare in this variety; why, he is not fully prepared to say. The essence of the lecture was that cancer of the tongue often comes from most trivial causes, and that all irritations and ulcerations in those above twenty-five years of life should be treated promptly and with the least meddling possible; and if operation is

deemed necessary, it should be done at an early date. He related how a mistake was made in that very arena by one of the best surgeons in the city, in diagnosticating cancer of the tongue when, by mere accident as the patient lay on the table ready for operation, it was discovered that the body was full of fresh syphilitic eruptions. On investigation it was shown that the young woman was a prostitute who used her tongue and mouth in sexual intercourse. The chief objection to the lecture is, it was rather too theoretical; the students have a surfeit of that already; it would have given a zest to the hour if more of the same or similar cases had been shown; or, if the hospital had no more cases of cancer of the tongue, to have grouped some of the cancers then in the building, for there were some, as I saw them in the wards after the lecture. To my mind, almost every step of a true clinical lecture should be illustrated from life, the differential diagnosis enforced by cases to the point, the prognosis shown by more advanced cases of the disease, or the same case presented to the class from time to time. Too often a lecture of this kind seems to bear the stamp of "anything to kill time." Especially in Melbourne, where the clinical teaching is meagre, the very best advantage should be taken of all that would carry any lessons to the students.

C. C. VANDERBECK.

LETTER FROM BERLIN.

Prof. Naunyn's Clinical Observations.—Relation of Fränkel's Pneumococcus to the Streptococcus pyogenes.—Persistence of the Spirochetæ of Obermeyer in Recurrent Fever for 14 days.—Multiple Arsenical Neuritis.—Paralysis from Injections of Ether.—Cause of Diabetic Coma.—Fermentations in the Stomach.—Therapeutics of Syphilis.—Curability of Cancer.—Creolin a Substitute for Creasote.

BERLIN, Nov. 9, 1888.

Professor Naunyn, the eminent clinician of Königsberg, who has just accepted a call to Strassburg, has published, as a sort of farewell present to his old northern University, a highly valuable collection of clinical observations. Your correspondent must content himself with alluding only to the most interesting parts of that publication. Prof. Naunyn has observed five cases of lobular pneumonia complicated with empyema, in which both Fränkel's pneumococcus and the streptococcus pyogenes were constantly found. These two microbes hold a certain relation to each other, inasmuch as one pathogenic germ prepares a favorable nidus for the other. Thus, the pus-germs easily develop and predominate in the lungs after the prior invasion of the pneumococcus. Naunyn also relates a case of recurrent fever, in which the spirochetæ of Obermeyer were observed for fourteen days in succession. Formerly it was always thought that these germs appeared in the blood only with the fever and disappeared after a critical fall of temperature. Of considerable interest are Naunyn's observations on paralysis as a symptom of acute arsenical poisoning. In chronic poisoning with arsenic, paralysis is not an unusual symptom, and in the acute toxic paralysis it is at times the only symptom apparent. This paralysis appears quite early, shortly after or in the course of the gastro-intestinal symptoms, and is an expression of a multiple nerve-affection rather than, as has been hitherto thought, of a spinal paralysis.

Of equal interest are Naunyn's observations on paralysis caused by subcutaneous injection of ether. Only a few cases of this ether paralysis have been described. In one case observed by him the paralysis was confined to the region of the ramus profundus radialis (posterior interosseous), while in another case the paralysis was sensory and affected the posterior cutaneous branch of the radial nerve, and lasted for three months. Naunyn believes that the action of an injection of ether (or oil of camphor) does not consist in any specific influence exerted by the ether on the central nervous system, but in a violent irritation of the peripheral sensory nerves directly affected. Another interesting statement made by Naunyn is that coma in diabetic patients is caused by oxybutyric acid circulating in the blood. This acid causes coma by depriving the blood of its alkaline constituents. Experimentally the author has also succeeded in checking the diabetic intoxication by supplying alkalies to the blood. It is therefore a fair inference that alkaline remedies are indicated in diabetic coma.

A larger essay of considerable practical importance is the one on fermentations in the stomach, from which we gather that the normal gastric contents, during the process of digestion, are almost free from germ-life, with the exception of some yeast-cells or some single bacteria. The filtrate of such gastric contents as contain free hydrochloric acid and pepsin may be kept for weeks in

an open vessel without any germ-life being observed. Indeed, the fluid can be inoculated with various microörganisms with impunity. This singular resistance to germ-life is to be attributed, first, to the free hydrochloric acid; for, if the gastric contents are neutralized with an alkali, germ-life develops quickly and abundantly. Pepsin appears also to have something to do with this resistance to microbes, for germs appear at once if the fluid is heated to the boiling-point and after being cooled inoculated with germs. This procedure of course destroys the pepsin. Bacteria cannot normally develop in the gastric juice, as they cannot escape the digestive action of pepsin. Naunyn mentions, as predisposing causes of gastric fermentations: 1. Mechanical insufficiency of the stomach, with secondary insufficiency of secretion, such as may occur in stenosis of the pylorus resulting from carcinoma, ulcer, or muscular weakness of the stomach. 2. Grave organic lesion of the gastric walls, with secondary insufficiency of secretion as occurs in broad carcinomata, and in atrophy of the mucous membrane. 3. Undue supply of neutralizing ingesta. As results of gastric fermentations Naunyn mentions: 1. Irritation of the mucous membrane; 2. Tympanites; 3. Auto-intoxication, such as dyspeptic coma; 4. Interference with normal mechanical procedures, such as peptonization and saccharization; 5. Disturbance of the intestinal functions by the entrance of irritating gastric contents into the intestines. As therapeutic measures Naunyn recommends in gastric fermentations: washing out of the stomach; antiseptic remedies, such as hydrochloric acid, or carbolic acid (three drops before meals); benzol, fifteen to twenty drops; or creasote (six drops). The diet should also be regulated, and a meat diet given in obstinate yeast-fermentation.

Naunyn is an authority on the therapeutics of syphilis. His latest suggestions in the treatment of syphilitic affections of the nervous system are very simple. He recommends, above all, an energetic inunction-treatment, *i. e.*, thirty to forty inunctions containing at least sixty or seventy-five grains of mercurial ointment. He has used as much as two and a half drachms for one inunction. The inunction is to last for fifteen or thirty minutes. Among other therapeutic measures, he advises careful attention to the mouth and skin, regulation of the bowels, selected and nourishing food, and exercise in fresh air. He orders iodide of potash from the beginning in doses of fifteen to forty-five grains a day. The duration of the entire treatment covers usually from eight to ten weeks. In diffuse nephritis and hepatitis mercury is to be used with caution, as it is ill borne.

The case of the Emperor Frederick has naturally again directed the attention of the profession to the medical treatment of cancer. Neudörfer has just published an interesting little pamphlet on the subject. Carcinosis, the author says, is very probably just as curable as syphilis or phthisis. The excision of a carcinoma, as of a hard chancre, is, as a rule, not far-reaching enough to prevent the infiltration of the surrounding tissues with the specific microbes and cells. He believes that the medicinal treatment of cancer should be tried more extensively than has been the case hitherto. The rind of condurango and Chian turpentine have often given promising results. There are also, as in phthisis, climates favorable for cure. On the plateau of Mexico and at the Cape of Good Hope, for instance, cancer is an exceptional disease. The principal office for the surgeon, in Neudörfer's opinion, is not the extirpation of the neoplasm, but the medicinal treatment of the cancer-cachexia, which is the chief factor in bringing about the death. The treatment of cancer is naturally much like that of phthisis. Creasote, which has been found to stimulate the nutrition of the blood-corpuscles, is of equal value in cancer and in phthisis. He has obtained decided results in the treatment of cancer with the following preparation:

℞ Creasoti puri,
Sodii bicarb.,
Olei morrhuæ . . . . . aa f ʒ v
M. Put in 100 gelatine capsules. Take three capsules three times daily after each meal.

A very eligible substitute for creasote is creolin, as it is not only cheaper than the latter, but is also a stimulant of digestion. He prescribes:

℞ Creolin . . . . . ♏ xv
Ext. glycyrrhizæ, q. s. ut ft. pil. No. 100.
Sig. Three pills three times daily.

Locally, Dr. Neudörfer prescribes, with the above pills:

℞ Creolin,
Ichthyol,
Iodide of potash . . . . aa gr. xl
Vaselin,
Lanolin . . . . . aa gr. xv
M. F. ung. Sig. Rub into the part three times daily.

Neudörfer boasts of three actual "cures" of cancer obtained with this treatment.

PERISCOPE.

Influence of the Menstrual Periods Upon the Sex of Children.

At the meeting of the Biological Society of Paris, October 13, 1888 (*Bulletin Médical*, Oct. 17, 1888), M. Dupuy stated that from the study of the statistics of more than two hundred families (over one thousand children) he had found that, the sex of the first child being known, it was possible to predict what would be the sex of the children yet to be born, and in some measure to choose the sex. He then went on to say: The first child being conceived in a menstrual period which we will designate by 1, if the child is a boy, all the children which will be conceived, for example, in the 11th, 13th, 15th, 105th, 107th, 109th, etc., menstrual periods following, will also be boys. All the children which will be conceived in an equal menstrual period, that is to say, in the 12th, 14th, 16th, 106th, 108th, 110th, after the first conception, will be girls.

So, says M. Dupuy, if the father of a family desires to have a girl, after having had a boy, he should count the number of menstrual periods passed by his wife since her last confinement, and bring about pregnancy in an equal menstrual period after the first confinement. If the first child, however, was a girl, then pregnancy should be secured in an odd period. All the children born in a twin pregnancy with a single placenta follow the rule.

He adds that this rule is true only for the children of the same couple. If one of the two parents changes, the count must be made afresh from the first confinement. M. Dupuy declares his ignorance of any cause for this regularity. He has established its existence empirically.

Terebene.

Dr. D. M. Cammann, in a paper upon observations on the use of terebene, gives the following summary of his results: Thirteen cases were of chronic bronchitis, most with more or less extensive pleuritic adhesions. Three were of acute bronchitis, ten of emphysema, two of asthma and bronchitis, ten of phthisis, one of pleurisy, and one of the third stage of pleuro-pneumonia. Two of these, both cases of acute bronchitis, were cured, one in four and the other in eleven days. Thirty-three cases were improved, most of them markedly, but a few only to a slight degree. Five were unimproved, two of the patients being obliged to discontinue the drug after two or three days, as it produced vomiting. The shortest time the treatment was continued in any case was four days, the longest time six months. The average length of treatment was a little over twenty-six days. Most of the patients took fifteen minims and some as much as half a drachm in a mucilaginous mixture four times daily. In all except three, the cough was improved, becoming softer and less frequent. In twenty-six, the quantity of the expectoration was lessened; in four it was unchanged, and in two it was increased. The latter were under treatment only one week, and it was found in some of the other cases that the expectoration was increased for the first few days and afterward diminished. In seventeen cases the expectoration became thinner and more watery; in six it was no thinner. In the other cases no note was kept in regard to this point. In those troubled with dyspnœa, the dyspnœa was diminished in thirteen and undiminished in eight. The patients noticed an increase in the urine in nine cases; no increase was noticed in fifteen. In many of the cases the appetite improved. In two cases the terebene caused vomiting, in two nausea, in one dizziness and nausea, and in two dizziness. These symptoms usually disappeared when the dose was reduced. It is beneficial in affections of the bronchial mucous membrane, both acute and chronic. It relieves the dyspnœa of emphysema, it is readily borne by the stomach, and it seems to have a resolvent action on pleuritic adhesions.—*N. Y. Med. Journal*, Nov. 10, 1888.

—The Trustees of the University of Pennsylvania have accepted the resignations of Prof. D. Hayes Agnew, from the Chair of Surgery, and of Prof. William Osler, from the Chair of Clinical Medicine. Both resignations are to take effect at the close of the present session, in 1889. Dr. John Ashhurst, Jr., has been nominated for the position to be vacated by Dr. Agnew.

—Dr. C. B. Shute and some Malden officials, says the *Ledger*, Nov. 28, went to Worcester some weeks ago to see a new patent ventilator in a hospital. Dr. Shute and Alderman Clark descended a shaft into which was blown the foul air from the building, in which were several typhoid fever cases. Dr. Shute died of the disease and Alderman Clark is down with what is regarded as a fatal attack of it.

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APPARENT DEATH IN THE NEW-BORN INFANT.

Everyone, with even a moderate obstetric practice, meets occasionally with cases of apparent death in the new-born infant. The subject is of interest not only from its exceedingly practical nature, but from the fact that neither the pathology nor the treatment of the conditions presented is absolutely settled. Further investigations are needed to determine whether the states of lividity from congestion, and pallor from anæmia of the superficies, are etiologically the same, and but different stages of the same process; or are as different in their etiology and real nature, as in their external appearance. No matter which view is correct, the usual division is important in both prognosis and treatment.

For the less serious cases, in which, although cyanosis is present, respiration is feebly and imperfectly performed, nothing succeeds better than the simple expedient of irritating the skin along the spine by somewhat vigorous friction with the fingers. Respiration and vigorous crying are soon established. In this particular class of cases nothing has given so much satisfaction as this manœuvre. When cyanosis is more marked, and especially if there is reason to think from a history of prolonged second stage that attempts at respiration have been made before birth, with aspiration of fluid into the air-passages, the mouth and throat should be cleared of mucus, etc., by a cloth introduced on the finger. The usual practice, under these circumstances, of immediately cutting the cord and allowing one or two drachms of blood to escape, before applying the ligature, probably relieves the heart and is to be commended; but much time should not be thus consumed. A hot bath favors bleeding and at the same time stimulates respiration. Cold water or brandy may also be sprinkled from a height at intervals to cause inspiration; but it seems to us that the plan of dipping a new-born infant into cold water should be used only under exceptional circumstances. Inversion of the infant is a logical and valuable method of treatment in all stages of asphyxia, and should be resorted to early. The other measures of treatment can be, at least in part, applied with the infant inverted. The judicious use of these measures will bring about respiration in the vast majority of cases of asphyxia livida. In some cases artificial respiration will be necessary. Sylvester's method can easily be used with the infant in an inverted position. Each of the other methods of producing artificial respiration has certain advantages. Schultze's method has few adherents in this country. Its apparent brutality will hardly permit it to be popular with the laity.

The methods of Byrd and Goodell are similar in principle and execution, and, owing to the gentleness of the manipulations employed, are especially applicable to feeble infants.

The prognosis is much more grave in asphyxia pallida; great feebleness in the action of the heart is added to the absence of respiration. Cutaneous stimulation by means of the hot bath, with intermittent sprinkling with cold water is not likely to succeed. Flagellation, which is permissible and useful in the livid form, is contra-indicated, lest the feebly acting heart should cease to beat. The cord should be quickly cut, the upper air-passages cleared of mucus, and artificial respiration resorted to, care being taken that the head is kept lower than the body. We prefer the method of Sylvester or Goodell, because of the less amount of exposure that is necessary, and less amount of shock that is inflicted. Jacobi has made the valuable recommendation that an enema of water at a temperature of 104° to 108° Fahr. be given. Perhaps a few drops of brandy could be added with advantage. Faradization of the phrenic nerve is a promising expedient, and of even greater promise in the livid form. One pole should be applied over the sterno-mastoid muscle, the other over the diaphragm. One electrode should be kept stationary, the other applied intermittently to bring about inspiration. Unfortunately a battery is not always at hand. Direct insufflation is at times resorted to, but has serious disadvantages. Where all secretions have not been removed from the throat, this foreign material is liable to be driven into the trachea and bronchi. The method of insufflation through a catheter, unless used with great care, is liable to cause rupture of the pulmonary air-vesicles and interlobular emphysema, as we have seen in one case. When mouth-to-mouth insufflation is used the stomach is likely to become inflated and still further embarrass respiration. Owing to the inherent dangers of the method, direct inflation should not be employed until more simple measures have failed. As a *dernier ressort*, in some cases, tracheotomy has been done and the catheter introduced directly into the trachea. Nor should it be forgotten that too much may be done, especially in feeble infants. Many cases are on record, similar to those reported by Goodell, in which the child has been put aside as dead, after failure of the usual methods of treatment, and afterward has been found alive. These cases show that the prognosis is sometimes worse in appearance than in reality.

TREATMENT OF FRACTURES AT THE ELBOW-JOINT.

In a very interesting paper in the *Archiv für klinische Chirurgie*, vol. xxxvii, part 3, Dr. Carl Lauenstein, of Hamburg, advocates treating fractures of the humerus at the elbow-joint with the forearm in a position of extension, instead of, as is customary, in a position of flexion. He was prompted to this practice by studying the condition of the elbow-joint in the person of a patient who died within a year after being treated in the usual way. The specimen showed that flexion of the arm had been secured at the expense of the fragments, and not in the joint.

This discovery led to further study of the anatomical conditions present in fractures of this sort, and Dr. Lauenstein came to the conclusion that the ordinary treatment is almost inevitably followed by permanent deformity of the arm, and that this misfortune would be avoided if the arm were kept extended while the reparative process goes on.

These views appear to have been arrived at by independent observations on the part of Dr. Lauenstein; but many of our readers are no doubt aware that they are not new; for in 1880 Dr. O. H. Allis, of Philadelphia, published, in the Annals of the Anatomical and Surgical Society of Brooklyn, an admirable paper, illustrated by drawings which are closely paralleled by those in Dr. Lauenstein's paper, and advo-

cating the same method of treating fractures at the lower end of the humerus.

Both of these papers suggest a very important point in the management of these fractures, namely, the avoidance of a deformity which consists in altering the normal relation of the position of the forearm to that of the upper arm.

The method proposed has much in its favor; but we think that good arms can be secured without departing from the more convenient and comfortable method of fixing the forearm in flexion. For this, however, one point, which is often, we fear, overlooked, must be constantly borne in mind, namely, that in the normal arm the axis of the forearm is placed at an obtuse angle to the axis of the upper arm. The rectangular splint generally employed in the treatment of fractures at the elbow-joint almost of necessity brings the axis of the forearm into the same plane with that of the upper arm, and this can only be done by forcing the lower fragment into an unnatural position. The result is sure to be a permanent deformity, and more or less functional disability.

To avoid this, the splint should be made with a double angle: one in the vertical and one in the horizontal plane, and these should correspond exactly to the angles of the uninjured arm. With this precaution, results can be obtained which leave nothing to be desired, and there is no good reason why deformity and impairment of function should be looked upon as a natural consequence of fractures of the humerus at the elbow-joint. A correct knowledge of the normal position of the forearm in flexion, as well as in extension, and a fair degree of mechanical skill would prevent a large number of the unfortunate results after fractures of this sort, and those who do not feel safe in treating them with the arm flexed would do well to adopt the method so forcibly demonstrated by Dr. Allis and now supported by the later arguments of Dr. Lauenstein.

INTRAPERITONEAL CYSTOTOMY.

Among the interesting publications on the subject of supra-pubic cystotomy which have recently appeared is one by Professor Rydygier, of Cracow, cited in the *Wiener med. Presse*, September 30, 1888, in which he recommends opening the bladder by an incision through the part of it which is covered by peritoneum. He is prompted to adopt this method by consideration of the difficulty of obtaining union by the first intention after an ordinary supra-pubic cystotomy, and of the tendency of the peritoneum to adhesive inflammation. In order to test the applicability of this plan, Rydygier made a series of experiments on dogs, and then, last December, performed the operation on a boy thirteen years old, who suffered with stone in the bladder. The result of this operation, and of several others on older patients, has been entirely satisfactory, union by first intention having followed in every case. This experience leads him to propose opening the bladder through the peritoneal cavity for the removal of vesical calculi, or of neoplasms in the bladder, as a formal method.

There can be no doubt that the dread of wounding the peritoneum, which has long been regarded as one of the greatest dangers in supra-pubic cystotomy, has always been much exaggerated; both in respect of its frequency and in respect of its consequences.

In 1875, Dr. Dulles, in analysis of the largest number of cases ever collated—at that time—found but three in which the peritoneum was said to have been "cut" or "burst," and but six in which death was attributed to peritonitis. These all occurred before the operation of supra-pubic lithotomy had attracted the attention which it has secured during the last thirteen years. At the present day, it may be said that an involuntary wounding of the peritoneum may always be avoided by a proper combination of anatomical knowledge and manual

dexterity; and, in the present status of abdominal surgery, an unavoidable wounding of the peritoneum can hardly be regarded as a formidable accident, or as one which would materially increase the slight inherent risks of a supra-pubic cystotomy.

A deliberate opening of the peritoneum is a somewhat different matter. Rydygier is not the first surgeon who has operated in this way. As long ago as 1723, Prœbisch is said to have opened the peritoneum intentionally in order to remove a stone from the bladder. In 1871, Mr.—now Sir—Joseph Lister undertook a supra-pubic lithotomy on a boy, in Edinburgh, and accidentally cut the peritoneum. His patient recovered so nicely that he soon after operated upon a man, and, relying upon his antiseptic methods, deliberately opened the general abdominal cavity and cut into the bladder where it is covered with peritoneum. This patient, however, died. In 1881, Langenbuch proposed opening the bladder through the abdominal cavity by a peculiar method *en-deux-temps*, which seems never to have been actually practised.

These facts are of historical interest in considering Rydygier's proposition, but they do not affect the credit to which he is entitled for placing the method of intra-peritoneal cystotomy on a basis thoughtfully planned, supported by experiment, and confirmed by actual experience on the human subject. Some acquaintance with the subject of supra-pubic cystotomy leads us to believe that the method suggested by Rydygier deserves the careful attention of surgeons, and that further experience may show that the bladder may be as safely opened through the abdominal cavity as through the prævesical tissues, and with a better chance of subsequent union by the first intention. Such a method would certainly be easier to carry out; and, if it proved successful in the hands of other operators, it would undoubtedly inaugurate a new era in cystotomy.

Book Reviews.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the Reporter.]

TREATISE ON THE DISEASES OF WOMEN. By Alexander J. C. Skene, M.D., Professor of Gynecology in the Long Island College Hospital, Brooklyn, N. Y., etc. Illustrated with 251 Engravings and 9 Chromo-Lithographs. 8vo, pp. 966. New York: D. Appleton & Co., 1888.

This work is written from a clinical standpoint. The subjects of the anatomy, physiology and pathology of the female sexual organs are not elaborated—only enough is said about them to enable the student and practitioner to appreciate the natural history of the diseases of these organs and to treat them intelligently. A feature of the book is the insertion of reports of cases, placed at the end of each chapter, to illustrate the principles set forth in it; or, to represent a-typical or complicated conditions. There is an interesting chapter devoted to gynecology as related to insanity in women, and the section on the diseases of the bladder and urethra embraces a third of the volume. While this detracts from the proportions of the book, viewed artistically, it adds very much to its practical value.

The operation for the cure of fistula in ano, by careful denudation and suturing, is noticed favorably, as likely to bring about a cure and preserve continence of feces. A more than usually favorable prognosis is given in regard to the catarrhs of the uterus. The pipette is used to make intra-uterine applications instead of the applicator or the generally abandoned syringe. The intra-uterine stem pessary is in high favor with Dr. Skene, but its dangers are sufficiently dwelt upon. He also relies upon the hypodermic needle and the larger aspirator more than the progressive surgeons of to-day; and he has not joined those who regard the tapping of ovarian or other intra-abdominal cysts as unjustifiable except under rare conditions. Early ovariotomy is not insisted upon.

The author's treatment of flexions is striking. Flexion is considered a deformity, and, in the chapter devoted to its consideration, only flexions resulting from error of development and from inflammatory or degenerative disease of the parenchyma of the womb are discussed.

The chapter devoted to the anatomy, physiology and injuries of the pelvic floor is in most respects admirable. The author still talks about the "perineal body," but this we can forgive him, since he makes it plain that this so-called body is simply a part of the supporting segment of the pelvic floor; that its functions do not depend on its being a wedge of indifferent tissue interposed between the outlets of the rectum and vagina, but upon the fact that the muscles of the pelvic floor, levator ani, transversus perinei, bulbo-cavernosus, and sphincter ani, centre here. This important fact is well brought out and the injuries of these structures are considered; and not lacerations of mere skin, mucous membrane and connective tissue. The descriptions of the various operative procedures for the cure of these injuries we think could have been made plainer, and the operation recommended for so-called incomplete laceration is not the one we have considered best; but the principles laid down are so sound and true that the practitioner fully imbued with them cannot but obtain good results.

The subject of the dislocations of the uterus is presented better than in any work with which we are familiar, excepting perhaps Hart and Barbour's Manual.

In the preface it is stated that unsettled questions are omitted. Perhaps this accounts for the chapters on diseases of the ovaries, pelvic peritonitis and pelvic cellulitis. Had these been written five years ago they would be considered excellent. But the advances made since that time are only dimly hinted at, and not clearly presented.

Lack of space prevents a consideration of the work in further detail. We regard the book as one of the best extant on gynecology, and especially so for the student and general practitioner; and we think that but few specialists can read it without profit as well as pleasure. The illustrations are of more than usual excellence, and many of them are original. The printing also is good, but the paper is rather poor.

PAMPHLET NOTICES.

[Any reader of the REPORTER who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request stating where the notice was seen and *enclosing a postage-stamp.*]

156. CHRONIC PYELITIS, SUCCESSFULLY TREATED BY KOLPO-URETERO-CYSTOTOMY. IRRIGATION OF THE PELVIS OF THE KIDNEY, AND INTRA-VAGINAL DRAINAGE. By NATHAN BOZEMAN, M.D., New York. From the *Amer. Journal of the Med. Sciences*, March and April, 1888. 19 pages.

157. RENAL TENESMUS. By NATHAN BOZEMAN, M.D., New York. From the *Medical Record*, Aug. 4, 1888. 36 pages.

158. THE AMERICAN HIP-SPLINT. By DR. A. B. JUDSON, New York. From the *Transactions of the Ninth International Med. Congress.* Vol. III. 4 pages.

159 THE ELECTRO-MAGNET IN REMOVAL OF STEEL FROM THE INTERIOR OF THE EYE. By ALVIN A. HUBBELL, M.D., Buffalo, N. Y. From the *Buffalo Med. and Surg. Journal*, July, 1888. 8 pages.

160. TUBERCULAR DIATHESIS. By W. C. CHAPMAN, M.D., Toledo, Ohio. From the *Columbus Med. Journal*, July, 1888. 9 pages.

161. HEREDITY. By JAMES THOMAS LEARCY, of Tuscaloosa, Alabama. From the *Transactions of the Med. Association of the State of Alabama.* 16 pages.

162. SOME OF THE ADVANTAGES OF THE UNION OF MEDICAL SCHOOL AND UNIVERSITY. By WILLIAM H. WELCH, M.D., Baltimore, Md. From the *New Englander and Yale Review*, September, 1888. 19 pages.

156. This paper by Dr. Bozeman contains a portion of what appears in his more extensive paper read before the Ninth Inter. Med. Congress, and already noticed as pamphlet No. 154, in these columns. It is based upon his study of and experiences with a patient whom he treated successfully by the method here described, and is admirably illustrated.

157. In this paper Dr. Bozeman discusses a curious condition which he distinguishes from what is commonly called renal colic, and which he states to be a "frequent result of chronic cystitis and ureteritis, in contradistinction to pyelitis, the usual result of urethrocele, cystitis and ureteritis." He also describes fully the method of treatment which has proved most satisfactory in his experience.

158. Dr. Judson's pamphlet contains a short, but excellent, historical sketch of the invention of the American Hip-Splint, and explains how it is entitled to the name. In addition he gives some important practical points in the early diagnosis of hip-joint disease, and one or two hints in regard to its treatment. His pamphlet also contains three figures showing certain modifications in the hip-splint which he has designed.

159. Dr. Hubbell describes the use of the electro-magnet for the removal of fragments of steel from the interior of the eye, and a form of magnet, of unusual power, which he had made by an electrician. This instrument is of convenient size, and its efficiency has been proved in two cases. His pamphlet contains an illustration of the magnet, and good description of the way in which this method of extraction should be carried out.

160. Dr. Chapman's paper, which was read before the Ohio State Medical Society, contains a thoughtful and interesting study of phthisis, and lays great stress upon the hereditary tendency of certain individuals to develop the disease. The author inclines to the belief that it is a mistake to apply the term solely to cases in which tubercle bacilli are found, and that other micro-organisms may set up the process of wasting and destruction of the lungs which is popularly called consumption. We can heartily commend his pamphlet to the attention of our readers, who will find it full of instructive and suggestive thoughts.

161. Dr. Learcy's pamphlet contains a study of the principles of generation, and an argument for the view that physical and mental characteristics are the result of inheritance, and that their cultivation depends upon repeated action. The author seems to be a pronounced believer in the doctrine of evolution, and states his belief that man was originally a-sexual, the female being the type of the species and man a variation from it.

162. In this address, which was delivered at Yale University, June 26, 1888, Dr. Welch makes an able argument for the union of medical schools with universities, or rather, for the formation of medical departments in universities, as an integral part of them. The example of German medical teaching, and the high development of the science of medicine in Germany, furnish a motive to much that he says; and all that he says is with the object of elevating the standard of medical education in the United States.

We cannot here repeat or even summarize his argument; but all the friends of higher medical education in the country would do well to study it for themselves.

—The annual banquet of the Ex-Resident and Resident Physicians of the Philadelphia Hospital, Blockley, was held at the Colonnade Hotel Dec. 4. Dr. Elmer, of Bridgeton, N. J., was elected President for the ensuing year.

CORRESPONDENCE.

Prevention of Conception.

TO THE EDITOR.

Sir: It seems to me that this subject is an important one and that it deserves careful consideration from medical men. We know that many, in all classes, are experimenting for the purpose of limiting the number of offspring, and that many women who marry nowadays either have a preventive which they intend to try, or hope to find one.

An inquiry into the cause for this state of affairs is certainly within the province of a medical journal. There can be no doubt of the desirability of preventing conception in cases of deformed pelvis, and all anomalies of the body which make delivery impossible; but I am not so sure of the desirability of preventive measures in all cases of syphilis, tuberculosis, deaf-mutism, derangements of nervous equilibrium, etc. When persons known to be subject to these disorders are allowed by law to enter into an alliance, the primary object of which is to perpetuate the species, the physician is not bound to interfere after the agreement is binding, unless the case is an aggravated one. The reason for such an opinion lies in the fact that preventive measures, if applied promiscuously to even one class of cases, would spread too far. Women even more than men dislike toil, hardship and suffering; and if it were once perfectly clear to the female mind that she is at liberty to limit this most disagreeable duty she would do it. The talk about mother-love being sufficient to make the human female endure the ordeal of delivery in order to become possessed of offspring is nonsense. Her nature may be altogether changed by circumstances, so as to bear but slight resemblance to what we are accustomed to consider natural. Witness the character of the Roman women who could calmly see men eaten by wild beasts, or butchered by their fellows!

On the whole, man cannot improve upon the Creator's plans for populating the earth. Women seek relief from the burden, because their physical suffering is too great to be borne. If the wife cannot influence the husband to have mercy on her in this respect, the physician should not be expected to atone for his brutality, and practically to cultivate his evil passions instead of relieving both of a grievous burden.

Women's health is an argument strongly urged; but conception may be a means of obtaining at least partial rest for the sexual function. If immunity from conception were guaranteed, women would be more willing to permit sexual indulgence. The evils of excessive venery would then become factors in the lives of both husband and wife. In this discussion the unfortunates who indulge their appetites out of wedlock receive neither countenance nor consideration, and no scheme for the conduct of married life concerns them. Yet they are made of the same flesh, and feel the same anguish, and present as many difficulties in the time of gestation as their virtuous sisters. The harlot, with no chance at all to make her offspring comfortable and happy, is consigned to torment, while it is proposed that those who have many kind offices to bestow upon their progeny should be told how to keep them unborn.

Perhaps it will sound like heresy to say so; but observation teaches that the greatest source of ill-health in mothers is not the bearing of children, but the way they spend their lives. How many physicians can think of half a dozen women who make a proper use of all the means within their power to make their bodies perfect? When an effort is made to have a patient, who complains that bearing children is exhausting her vital strength, or who really needs a tonic to the nervous system for some other reason, carry out a hygienic plan of treatment, the result is often far from satisfactory. Children were once considered necessary to furnish material to replenish the decimated ranks of armies; to cultivate the soil, to found colonies; and their appearance was welcomed with joy. The patriarch's wife said: "*Give me children* or I perish." The American wife cries: "*Give me no children lest I perish.*"

During the past week the writer attended a young woman in her third confinement. She has been married five years, and is the mother of three living children, and has had one miscarriage. Her husband is a healthy young farmer, and she is small, though well proportioned. After her confinement was over she said: "Now, Doctor, what shall we do to keep from having babies after this?"

In a case like this, what should be done? It is sincerely to be hoped that the present discussion may give us more light, if we are not justified in absolutely refusing to prescribe a prevention for conception.

Yours truly,

JAMES E. FREE, M.D.

Benezett, Pa.,
Nov. 22, 1888.

Treatment of Boils.

To the Editor.

Sir: In the Reporter, Nov. 17, 1888, I notice an article on "A Crop of Boils," by Dr. William M. Capp, in which he gives the pathology of the affection in a very scientific way. This leads me to believe that he understands the nature of boils. But his treatment is too skillful and overlooks the fact that a faulty nutrition is the cause of boils; if he will direct his treatment to the organs of digestion and introduce iron into the blood in such a way that it will be assimilated and build up broken-down tissue, he will, I think, succeed in curing boils.

I beg leave to suggest the following treatment:

℞ Tinct. ferri chlor. . . . . gtt. xv
Liquor potassii arsenitis . . . . . gtt. iii
Aquæ . . . . . f℥ ss
Take at a dose after each meal.

Use locally carbolized camphor, and a poultice when there is much inflammation. Also give small doses of Epsom salt to prevent constipation. This treatment will add another to the list of "sure cures."

Yours truly,
T. L. Craig, M.D.

Benedict, Kansas,
Nov. 20, 1888.

Erratum.

The last two lines on page 645 of the Reporter, November 24, should read: "The Medical and Surgical Reporter for Oct. 27," instead of for "Nov. 3."

Yours truly,
Ernest C. Helm.

Beloit, Wis.,
Nov. 27, 1888.

—The Board of Health of Jacksonville, Fla., has adopted resolutions permitting all persons to enter the city in day-time after Dec. 10, and all refugees to return without restriction by Dec. 15.

—Dr. W. B. Dorsett communicates to the *Weekly Med. Review*, Nov. 24, 1888, an account of a case in which a baby at birth had the lower two-thirds of the stomach and all of the small intestines, as far as the ileo-cæcal junction, including the greater portion of the mesentery, entirely outside of the abdominal cavity. An operation was done for the deformity, but the child died.

Notes and Comments.

Sand-Bur in the Larynx.

Dr. William B. Dewees reports the following case in the *Kansas City Med. Index*, Oct., 1888.

Miss B——, 21 years old, while out walking with companions, picked several sand-burs from her dress, which in turn fastened to the kid glove on her hand, from whence she endeavored to dislodge them with her teeth. Engaged in this act, a sudden, unguarded inspiration carried one of the burs into her throat, lodging in the larynx. The immediate suffering and excitement promptly brought the father with a carriage to the rescue, who forthwith conveyed her to my office. A careful, thorough examination, aided by Tobold's large reflector and lamp, proved vain to locate the foreign body. Localized pain within the larynx, an irritative, hacking cough, painful deglutition and hoarseness of voice, which was scarce above a whisper, constituted the leading train of symptoms. All considered the case as manifesting no immediate seriousness, and accordingly an expectant course of treatment was adopted, which consisted in advising absolute quiet in regard to speech and spraying the larynx and adjacent parts twice daily with a ten per cent. solution of cocaine.

The case progressed favorably, nothing in addition to the foregoing symptoms manifesting itself, except a blood-tinged expectoration, until the tenth day, when, soon after rising in the morning, a violent fit of coughing was invoked, which brought forth the *entire bur*, imbedded within a coating of mucus. Immediately all suffering ceased, the voice gradually regaining its normal tone.

Latent Carcinoma of the Dura Mater.

At the meeting of the Berlin Medical Society, October 11, 1888, Dr. Loewenmeyer exhibited a cancer of the dura mater, which had produced three large perforations in the skull. The specimens were removed from a man 44 years old, who died of carcinoma of the lung. A strange thing is that the tumor of the dura mater, in spite of the considerable destruction which it had made in the skull, had not produced the least symptoms; and it was a great surprise to meet with it at the autopsy. Large tumors of the dura mater are nearly always sarcomas; but in this case the structure of carcinoma was as nice as possible.—*Bulletin Médical*, October 21, 1888.

Glycerine Enemata in Children.

In a communication to the *Lancet*, Nov. 10, 1888, Mr. G. A. Carpenter says that during the past four months glycerine enemata have been used at the Evelina Hospital to the exclusion of purgatives, for the treatment of constipation among the patients. He gives a tabular statement of the results obtained from 214 injections given to 63 children, and says that an action of the bowels followed in five minutes or under in ninety-five instances; in ninety in thirty minutes or less; while in four the time was not recorded. Fifteen injections failed to relieve within the above-mentioned times, and intervals varying between thirty-five minutes and eleven hours were noticed in these. If one analyzes, he says, the fifteen instances in which more than thirty minutes elapsed before any action of the bowels took place, it will be noticed that they occurred in ten children, of which the most marked, as regards the length of time elapsing, are the cases of two special patients. It is worthy of note, he says, that five of the ten cases were suffering from tubercular disease in some form or another; three were osteotomies, and in consequence restrained from movements; one was a fractured femur treated in a double Bryant's splint; and, lastly, one was a case of chorea, in which, as is often the case, constipation was marked. Seven of the ten children were girls.

Coming to the failures, he finds that an osteotomy (in a girl) was accountable for a want of success and a return of the injection on three occasions; but in this child the injections were attended with success on eighteen different occasions, the bowels being relieved with one exception within the half-hour. In a case of tubercular disease of the spine, the first glycerine enema acted efficiently, an evacuation of the bowels occurring in five minutes; but a dose of three drachms failed later on, and a repetition gave no relief. This also was a girl. A knee excision (in a girl) shows one failure and three successes, the average time required for the injections to act being thirteen minutes. In the case of a child suffering with meningitis, the enema was returned, and not repeated. In a child with "pulpy" elbow, there was one failure and two successful injections. A case of suppuration of the antrum, he says, is responsible for one failure and one success. Five of these children were girls, and one was a boy. In all of the failures it will be noted that the bowels were capable of responding to glycerine stimulation at one time or another, and in no case was there complete failure.

As regards the quantity of glycerine used for an enema, he states that one drachm was given to 156 cases; a drachm and a half to forty-eight; two drachms to seven; and on two occasions three drachms were injected. In 154 instances the injections were followed by normal motions; in twenty-six the motions were loose; in eighteen they were of more than natural consistency; in six the enemata were followed by scybala; and in ten they were either returned or failed to act. In no instance were the enemata attended with unpleasant symptoms, either locally or constitutionally.

Creoline.

Dr. L. Lichtwitz, of Bordeaux, in a communication on creoline, in the *Bulletin Médical*, September 30, 1888, concludes that creoline is a disinfectant (deodorant) superior to other agents, and that whenever it obviates bad odors formed in the nasal or buccal cavities, or in the ears—from ozæna, ulcerated malignant tumors, fetid otorrhœa, etc.—it should be employed. It diminishes the pathological secretions from atrophic pharyngo-rhinitis, "fibrinous" rhinitis, and otorrhœa. It is a powerful antiseptic and easy of application; being non-toxic, it is preferable to other antiseptics.

[This estimate of the value of creoline as an antiseptic is probably hasty. Other experimenters have questioned its value, and have shown that it sometimes produces toxic effects similar to those caused by carbolic acid. It is clear that it should be used only with caution.—Editor of the REPORTER.]

Electric Prostration.

Several cases of this new malady are reported from Creusot, France. It affects workers under electric light. The light exceeds 100,000 candle power, and it appears that it is this excess of light, and not the heat, which produces the nervous symptoms. A painful sensation in the throat, face, and temples is first noticed, then the skin becomes coppery red, and irritation is felt about the eyes; much lachrymation ensues, and these symptoms then disappear, whilst the skin peels off in five days. The effects are comparable to those produced by walking over fresh snow in the sunlight, and may be regarded as a sort of "sun-burning."—*Lancet*, Oct. 27, 1888.

Differential Diagnosis of Twisted Pedicle.

An interesting discussion took place at the British Gynæcological Society recently, on the means of distinguishing between a twisted pedicle in ovarian cyst and rupture of an ectopic pregnancy. The diagnosis is one which few practitioners would care to attempt, but it is in reality fairly simple, though in this, as in other intra-abdominal affections, the surgeon is exposed to surprises on opening up the cavity. The collapse in rupture of extra-uterine gestation is sudden and complete, the tumor, if any has been perceived, has disappeared, to be replaced by symptoms of internal hemorrhage and hæmatocele, and the pain is sharp. In twisted pedicle, on the other hand, the symptoms come on slowly, and the abdominal tenderness is extreme. The tumor is tenser than ever. As pointed out by Dr. Heywood Smith, the pulse may afford some help in arriving at a diagnosis, the hemorrhage being limited to the cyst in the one case, but practically unlimited in the other. In extra-uterine pregnancy the symptoms rapidly run on to a fatal termination, unless relieved by abdominal section; whereas in the other, they may pass off in the course of a week, and the tumor become smaller. An important point in the diagnosis is evidently the presence of symptoms pointing to pregnancy, though their absence is not equally significant.—*Medical Press and Circular*, Oct. 31, 1888.

Acute Obstruction of the Bowels.

Dr. Coppens, Chief of the Surgical Clinic in the Lille Faculty of Medicine, has a paper on acute obstruction of the bowels and peritonitis from perforation, in the *Archives générales de Médecine*, October, 1888. He concludes that, of all varieties of false obstruction, peritonitis from perforation is the only one that it is possible to confound with acute obstruction of the bowels—an error which has been often committed. The diagnosis between the two affections is essential before treatment can be thought of. This diagnosis, he says, is possible. The most important differential points are drawn from an examination of the temperature, and of the degree and mode of appearance of the meteorism. Contrary to what has been maintained hitherto, he asserts that it is in peritonitis, and not in strangulation, that tympanites is met with most frequently and in the highest degree. If it is possible to distinguish acute intestinal obstruction from false, it is nearly always impossible, in the case of true obstruction, to determine its variety. But this, he says, is of no importance whatever from the point of view of treatment. He regards it as dangerous to resort to mild measures for too long a time. The abdominal incision, he says, should be median and large enough to ensure rapidity and ease in exploration.

Saccharine.

The *Lancet*, Oct. 27, 1888, says that the true position of saccharine is becoming somewhat hard to define. Its employment in the preparation of many substances liable to duty has already been prohibited, but this course of action was quite compatible with the possession of the most harmless properties. In a recent text-book on therapeutics, the author, when dealing with saccharine, appended the following disparaging foot-note: "The present is probably as good as any other place in the book to notice a substance whose use in practical medicine depends upon its lack of medicinal properties." Still, of late there have appeared several paragraphs in various journals referring to the report of a commission of Paris doctors, and their adverse verdict has already served to disquiet many diabetics, who had hitherto placed full confidence in saccharine. In the abbreviated form in which it has reached us, this report does not amount to very much. It starts with the assumption that saccharine is antiseptic; but this fact rests upon a very slender foundation—its power of retarding putrefactive changes in the urine eliminated during its employment. The main conclusions of the French commission are that it seriously troubles the digestive functions and increases dyspepsia, and should be prohibited as an article of food. These statements are not in accordance with those of very many previous observers, who have studied the action of saccharine, and found it to be mainly negative. Large quantities have been taken by men, and have been administered to animals, without causing any symptoms of any kind. The report merits attention, although it is so widely at variance with previous experience that it seems probable that some oversight has led to these conclusions.

For a succinct statement of the properties and uses of saccharine, our readers are referred to an Editorial in the REPORTER, June 23, 1888.

NEWS.

—Typhoid fever is reported to be epidemic in Brooklyn, New York.

—Dr. John H. Larrabee, the eldest son of Dr. J. A. Larrabee, died in Louisville, Nov. 17, 1888.

—The steamship Bolivia arrived at New York, Dec. 2, from Gibraltar, with small-pox on board.

—Naples is to have a new University building at an estimated cost of about 16,000,000 francs.

—The physicians of Lansing, Mich., are said to have combined to protect themselves from patients who do not pay.

—Typhoid fever is prevalent in Providence, Rhode Island. Seventy-five cases are said to have been reported.

—There was one case each of variola, varioloid, and scarlatina at the Municipal Hospital of this city during November.

—It is stated that the importation of saccharin and substances containing it has been forbidden in France and Algeria.

—Pleuro-pneumonia has developed among the cattle in Monroe County, New York. One hundred and fifty animals are said to have been killed.

—Dr. W. B. Boyd, of Bloomington, Illinois, committed suicide Nov. 30, by shooting himself. He is said to have been in poor health for some time.

—Dr. G. A. Slocomb is credited with having safely delivered a woman in Millbury, Mass., of four girl babies, all of whom are alive, though one is very delicate.

—Mr. Montagu Perceval states in a note to the *Lancet*, Nov. 17, 1888, that he has found antipyrin in two-grain doses every hour very useful in laryngismus stridulus.

—Two new cases of yellow fever were reported in Jacksonville, Fla., Dec. 2, but no deaths. The total number of cases up to that time was 4669; total number of deaths 410.

—Dr. J. Cheston Morris appeared before the Finance Committee of Councils of this city, Dec. 3, to advocate the appropriation for a milk inspector, to act under the supervision of the Board of Health.

—A woman living in Burlington, N. J., made a mistake in taking a dose of medicine recently, which nearly cost her her life. She desired to take some cough mixture, but, instead, picked up a bottle and took a teaspoonful of tincture of iodine.

HUMOR.

"I AM ON MY WAY HOME, Doctor," said a citizen who was after some free advice, "and I'm tired and worn out. What ought I to take?" "Take a cab," replied the intelligent physician.—*Worcester Gazette.*

CITIZEN: "What are you doing with that man?" Policeman: "I have just arrested him." Citizen: "But he's as deaf as a post." Policeman: "He'll get his hearing before the magistrate."—*Harper's Bazar.*

DISCHARGED FOR CAUSE.—"Why did you leave your last place?" "Sure I worr discharged for doin' well, mum." "Discharged for doing well? Why, where were you?" "I worr in the harspital, mum."—*Harper's Bazar.*

YOUNG DOCTOR (to hospital superintendent)—"I want no interference, sir, with my directions. I know my business. I have walked all the hospitals of London and Paris." Superintendent—"You may have walked foreign hospitals, sir; but you'll find that I run this one."

OLD LADY—"You seem to have a cold, sir." Stranger—"Yes, madam." Old Lady—"Well, I tell you what to do. Jes' go home and put your feet in a tub o' hot mustard-water an'—" Stranger (gruffly)—"That's fine advice to give a man with a cork leg; now, ain't it?"

METEOROLOGICAL ITEM.—Miss Bunker Hill—"Do you have much Indian summer in Colorado?" Major Wester—"Yes, we have a great deal more Indian summer than you do here in the East." "I wonder why that is so?" "Because we have got more Indians, I reckon."—*Texas Siftings.*

WASTEFUL.—"But what an awful lot o' money those high-toned travelers waste for drink," said Uncle Abner, as he laid down his newspaper. "A man who'll pay a hundred dollars for a saloon passage to England when he can get it in the steerage for twenty is a slave to rum—that's what I say!"—*Life.*

THERE HAD BEEN A RUNAWAY; a pair of horses were down, a carriage smashed to pieces, and the driver and a lady lay groaning on the grass with their hurts. The street-car stopped and many got off to render aid. Among those who stood on the rear platform were two ladies, one of whom held up her hands and exclaimed: "Mercy on me! but what an awful, awful affair! How long did you say you boiled your grape jelly, Mrs. Smith?"